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State of Maryland / Department of Health and Mental Hygiene 00 35002

												Reg. No.		
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Amended #20b, nls, Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 10/19/00, Allegany Co. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Deeth Day **Physician** ANN RITA WELSH OCTOBER 12, 2000 1715 /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ALLEGANY COUNTY NURSING HOME CUMBERLAND If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthpleca (Stata or Foraign Country) **Funeral** 1□M 2₩F Months Days Yrs. 84 Director 234-09-4022 JULY 1,1916 WEST VIRGINIA Usual Residence of Deceden the Maryland 10c. City, Town or Location 10a. Stata 10b. County 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Modical Examinations to a potre dis-1√2 Yas 2 No Director ALLEGANY CUMBERLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 705 FAYETTE STREET 21502 U.S.A. Funeral death 11. Maritai Status 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian Black, White, atc. 72 hours efter 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify Specify: WHITE þ 3√ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Giva kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOME HOMEMAKER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked o any Injury or other traumatic eva once. DAVID PATRICK KENNEDY KATHERINE JOSEPHINE DUGAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DENNIS STEVENS / NEPHEW 854 CAMDEN AVENUE, CUMBERLAND, MD 21502 20b. Placa of Disposition (Name of cemetery, crematory or other place)

SS. PETER 7 PAUL CEM. 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/16/2000 CUMBERLAND, MD 21. Signature of Funeral Servica Licensee 22. Nama and Addrass of Facility UPCHURCH FUNERAL HOME, P.A. Teschurch 202 GREENE STREET, CUMBERLAND, MD shock, or heart failure. List *on*ly one cause on each line. 21502 Approximata Interval Batween Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical 2 YRS · CORONARY ANTERY DISEASE Examiner Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician end s the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical Due to (or as a consequenca of): signed by the e Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 3 Probably 4 Unknown 1 Yes 2 No DISSTRUCTIVE LUNG DISEASE þ 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed peed pege 2 s has 1 ☐ Yes 2 No 1 Yes 2 00 No certificate or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred Certification: 28a. Dete of Injury (Month, Day Year) 28c. tnjury at Work? After 1 Naturel 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: d in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homlcide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) end manner as steted.

2 Medical Examiner: On the bests of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of gertifier 29c. License number 29d. Date signed (Month, Day, Year) 10 14865 OUT. 18,2000 30. Neme and address of person who completed cause of death (ftem 23a) (Type, Print)

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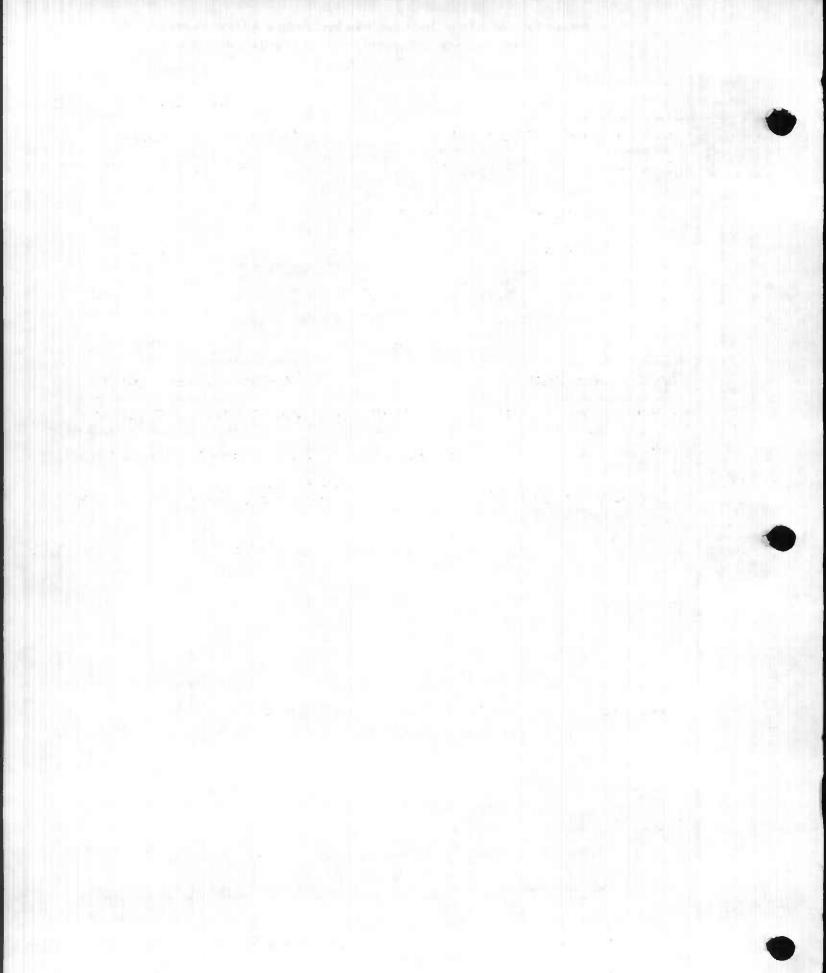
Registrar

BARREMA 31. Date filed (Month, Day, Year)

OCT 1 9 2000

500 Memorial Avenue, Cumberland, MD 32, Registrar's Signature

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vesi Frances Sivic Wright October 23, 2000 11:45 AM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Saint Vincent de Paul Nursing Center Allegany Frostburg If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1□M 20 F 213-74-9731 89 Ohlo 15-Nov-10 Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Allegany Maryland Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10300 Piney Mountain Road, S.W. 21532-U.S.A. 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Merital Status Black, White, etc. 1 ☐ Yes 2 No 1 Never Merried 2 Merried 1 Yes 2 No Specify Specify: White 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) John Sivic Frances Tomsic 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John E. Wright 13118 Bedford Road, N.E. Cumberland Maryland 21502-20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from Stete Sunset Memorial Park 25-Oct-00 Cumberland, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signeture of Funerel Service Licent 22. Name and Address of Facility bhu wie Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediete Cause (Finel disease or condition resulting in death) 2 Weeks Gangrene 3 Weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown heart failure 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? acchisive Vasenlar old are 1 ☐ Yes 2 M No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Other: 41 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Physician/Medical Examiner

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Physician

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parmit. Pages 1 and 2 should be filled within 72 hours after of Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Item any injury or other traumatic event, the Medical Examinat

Baltimore, Maryland 21215-0020

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g physician and as the burial-transit The law requires that the death certificate be executed Box 68760. 080 Records, P.O. page Division of Vital Certification: To

or Attending Physician: funeral director, After this To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Atta completely filled in by the fun

nus

29b. Signature and title of certifier

29a. Cartifier (Check only

27. Menner of Death

1 Netural

2 Accident

3 Suicide

4 Homicide

ollm MD

29c. License number

1 Yes 2 No

28c. Injury et Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Date signed (Month, Day, Year) 10/24 00

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Name and address of person who completed cause of death (flem 23a) (Type, Print)
 S.L. Sandhir, M.D., 48 Tam Terrace, Frostburg, Maryland 21532

State Registrar

31. Date filed (Month, Day, Year) OCT 2 4 2000

5 Pending investigation

6 Could not be determined

32. Registrar's Signature

28a. Dete of Injury (Month, Day Year)

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28b. Time of

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 27, Will Christian Oct 2000 09:00am /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13807 Florida Avenue Cresaptown Allegany If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 10M 20F Months Hours Yrs. Director 217-10-7162 94 1906 Germany Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show Inotified at 1 ☐ Yes 2 ☐ No Director Allegany Cresaptown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a or 13807 Florida Avenue 21502 USA Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Merried 2 ☐ Married Yes 20 No 21215-0020 5 1□ Yes 2□ No X Specify: Specify: White à 3 Widowed 4 □ Divorced Year or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 master machinist textile Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental is marked Christian Will Ottilie M (Saurer) 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) nt of Health a If from 27 is or other trac Clara Mynhier 13807 Florida Avenue; Cresaptown, MD21502 da Wall to Fosition 20b. Plece of Disposition (Name of 20c. Location - City or Town, Stata cemetery, crematory or other place) 1 Buriel 2 Cremetion 3 Removel from State
4 Donation 5 Other (Specify) 10/30 Scarpelli Funeral Home 2000 Cresaptown, MD 22 Name and Address of Facility Scarpelli Funeral Home P.A. 21. Signeture of Funeral Service Licensee Cumberland, Maryland 23e. Pert1. Enter the disease, of confplications that callsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last Box 68760. Physician/Medical Due to (or es a consequence of): 950 P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Records. 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? 1 ☐ Yes 2 PNo 1 ☐ Yes 2 ☐ No Division of Vitai 25. Was case referred to medicat axaminer? Attending Physician: Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After 5 Pending 1 PNeturat 1 ☐ Yes 2 ☐ No death. 4 hours after death 2 Accident investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) In 24 hour.
The Funeral Direction of the Puneral Direction of the Puner 8 4 ☐ Homicide 6 Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) J. Vue 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) SETON DR. CUMBERLAND, Md. CLARENCE J. VINCENT M.D 31. Date filed CT. 3.0°2000 32 Registrar's Signature State Registrar

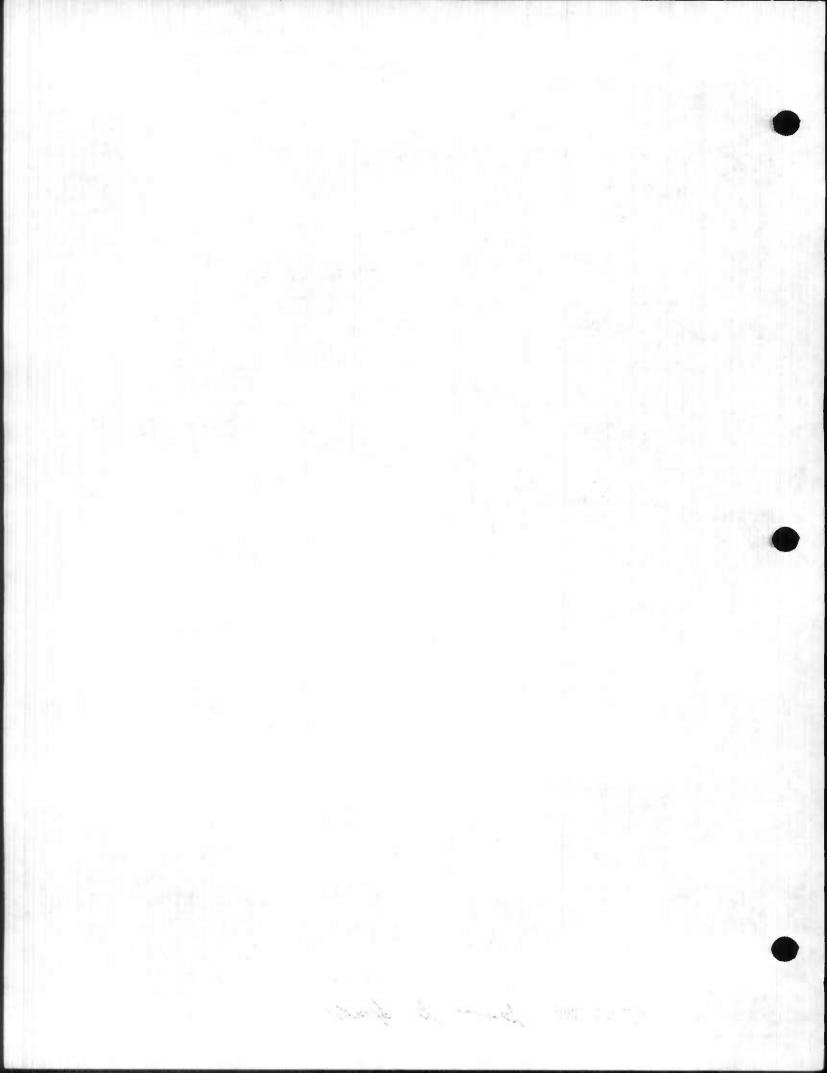
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State of Maryland / Departm

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an al			el Woolard			OCT.	28, 2000	0020 AM
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5. Social Security Number 212-04-8170	6. Sex 1 □ ★ M		e (In yrs. last birthda 18 Yrs.	y) If Under 1 Year Months Deys		8. Date of Bird (Month, Da	th ly. Year) 14, 1982	9. Birthplaca (State or Foreign Country) Maryland
Usual Residence of Decede 10a. State 10b. Co			10c. City, Town or	Location		3	,,	10d. Inside City Limits
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27. Manner of Death 1 Netural 5 P 2 Accident if 3 Suicide 6 C 4 Homicide		On the basis of	examination and/or	ath occurred at the ti investigation, in my				nner es stated. and dua to the cause(s)
29a. Certifier 1 ☐ Certifier 2 ☑ Med	ncal Examiner:							
		and menner ste		29c. Licen	c.M.E		29d. Date signed OCT.	(Month, Dey, Year) 28, 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Edward John Williams 25 Oct 2000 6:15 PM 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Charlotte Hall Charlotte Hall Veterans Home St. Marys | Fraction 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1907 11XM 2□ F Pennsylvania Yrs. 93 216 44 9424 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland St. Marys Charlotte Hall 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 29449 Charlotte Hall Road 20622 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Bleck. White, etc. 1 N Yes 2 No If Yes, Give Year or Dates: 1923-44 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: white 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Chief Radioman US Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) unknown unknown 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Janet W. Stanley / daughter 3618 29th Street, Chesapeake Beach, MD 20732 20b. Ptece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Southern Mem. Gardens 10-28-00 Dunkirk, MD 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Rausch Funeral Home, P.A., Owings, MD 20736 23a. Pert1. Enter the disease, or complications the caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart teiture. List only one cause in each line. Approximete Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SICK SINW SYNDROME Due to (or es e consequence of): THEROSCHLERSTIC HEART dISEASE Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence ot): Due to (or es e consequence of): Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Em Bolism 1 Yea 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? FLEART 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one)

Physician /Medical Examiner

Examiner

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Completed

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Certification: To

4 ☐ Homicide

Department of Important: If any injury or another.

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The lew requires that the death certificate be executed funeral After or Attending after deeth.

Director: Aft
d in by the fur To the Hospital of within 24 hours at To the Funeral D completaly filled it

CONGEST?

25. Was case referred to medical examiner?

Other: Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 1 27. Manner of Death 28b. Time of

28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 1 Detural 5 Pending investigation TUYes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier

(Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PRESTON SOIL LANDVERMO 20602

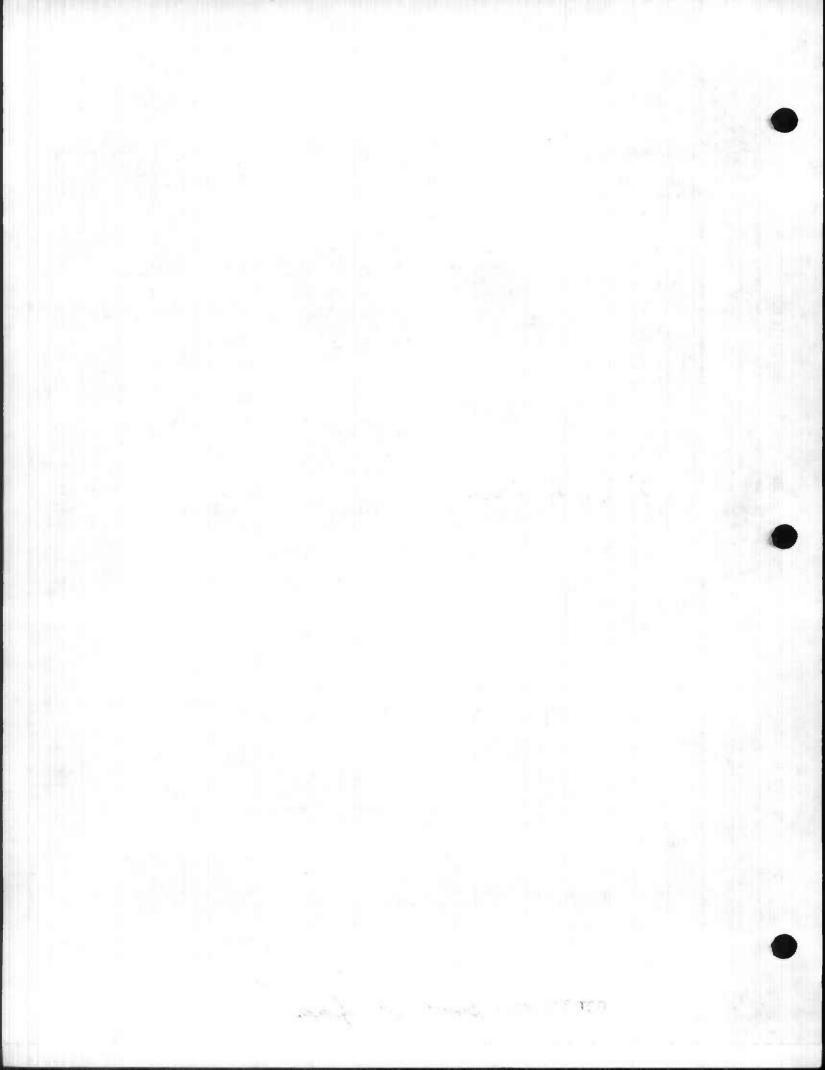
oct 26 2000

State Registrar

SATEL MO 32. Registrar's Signeture ASHVINKUMAR 31. Date filed (Month, Day, Year) 32. Rec OCT 3 0 2000 Gener

D44436

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

BEG NO.

	REGISTRAR		CERT				REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF			3. TIME OF DEATH
	Ernest		Walker			Oct.	2, DAY 20	OOO YEAR	8:40 a m
	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs. last birthde	(V) IF UNDER 1 Y	YEAR IF UNDER 24 HRS.				
	402-56-3924	1 💢 M 2 🗆 F	62 YRS	MONTHS C	DAYS HOURS MIN.	(Month, D			NPLACE (State or Foreign try)
	9e. FACILITY NAME (If not institution, give s	street and number)		9b. CITY, T	OWN OR LOCATION OF			COUNTY OF D	
FUNERAL DIRECTOR	Garrett County M	lemorial H	ospital		0akland			Garr	ett
2	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY								
H			10c. 0	CITY, TOWN OR					10d. INSIDE CITY LIMITS?
0		rlington		A:	rlington				1 💢 YES 2 🗌 NO
A	10e. STREET AND NUMBER				101. ZIP CODE		10g.	CITIZEN OF	WHAT COUNTRY?
E	3706 S. 14th St				22204			USA	
5	11. MARITAL STATUS	12. WAS DECEDENT	EYER IN U.S. ARMED		S DECENDENT OF HISP				E American Indian,
ВУ Б	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAY	R OR DATES		YES 2 NO Spe		in, etc.)	Spec	k, White, etc. White
O.	15. DECEDENT'S EDU	CATION		T'S USUAL OCC	UPATION	165.10	ND OF BUSINESS	MAPHIETEV	
H	(Specify only highest grade	completed)	(Give kind	of work done dur	ing most of working	100. KJ	ND OF BUSINESS	MUUSINT	
2	Elementary/Secondary (0-12)	College (1-4 or 5+)			tendent		Constru	iction	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			aper in					
	Carl	Wal.	leam		Frank		fle, Meiden Surnan		
띪	19e. INFORMANT'S NAME (Type/Print)	NGT							mpbell
2		T 7 - C			Street and Number or Run				
- 1	Viola C. Walker/	wire	3/00	S. 141	th St., Ar	lington	1, Va. 2	22204	
	20a. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Rem. 4 Donation 5 Other (Specify)	oval from State	20b. PLACE AND DAT cemetery, crematory of	or other place!	The state of the s	DATE	20c. LOCATION		
	21. SIGNATURE OF FUNERAL SERVICE LIC	FNSFF	Und		Cemetery		00 Oak	Land,	Md.
	- C 00 A	0			ewart Fune		10		
	Scalley N	Mans			S. Second			Md.	21550
NO	iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	Met	OR AS A CONSEQUENCE	tie	. Ora	la	to C	a	Monet and Death
HTIFICATI	CAUSE (Disease or injury that initiated events resulting in death) LAST	C. DUE TO (C	OR AS A CONSEQUENCE						i
CERTIFICATI	CAUSE (Disease or injury that initiated events resulting in death) LAST	d							
	CAUSE (Disease or injury that initiated events	d		g in the unde	rlying cause given i	n Pert I. 24	a. WAS AN AUTOF	SY 24b	WERE AUTOPSY FINDINGS
	CAUSE (Disease or injury that initiated events resulting in death) LAST	d		g in the unde	rlying cause given i		PERFORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
EDICAL	CAUSE (Disease or injury that initiated events resulting in death) LAST	d		g in the unde	riying cause given i				AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MEDICAL	CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other significant condition	d	eath but not resultin			1:	PERFORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDICAL	CAUSE (Disease or injury that initiated events resulting in death) LAST	d	eath but not resultin	YES 🗆 NO	D D UNCERTA	1:	PERFORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
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12+1VA

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and heart. Page 6 may be retained by the hospital or attending physician.

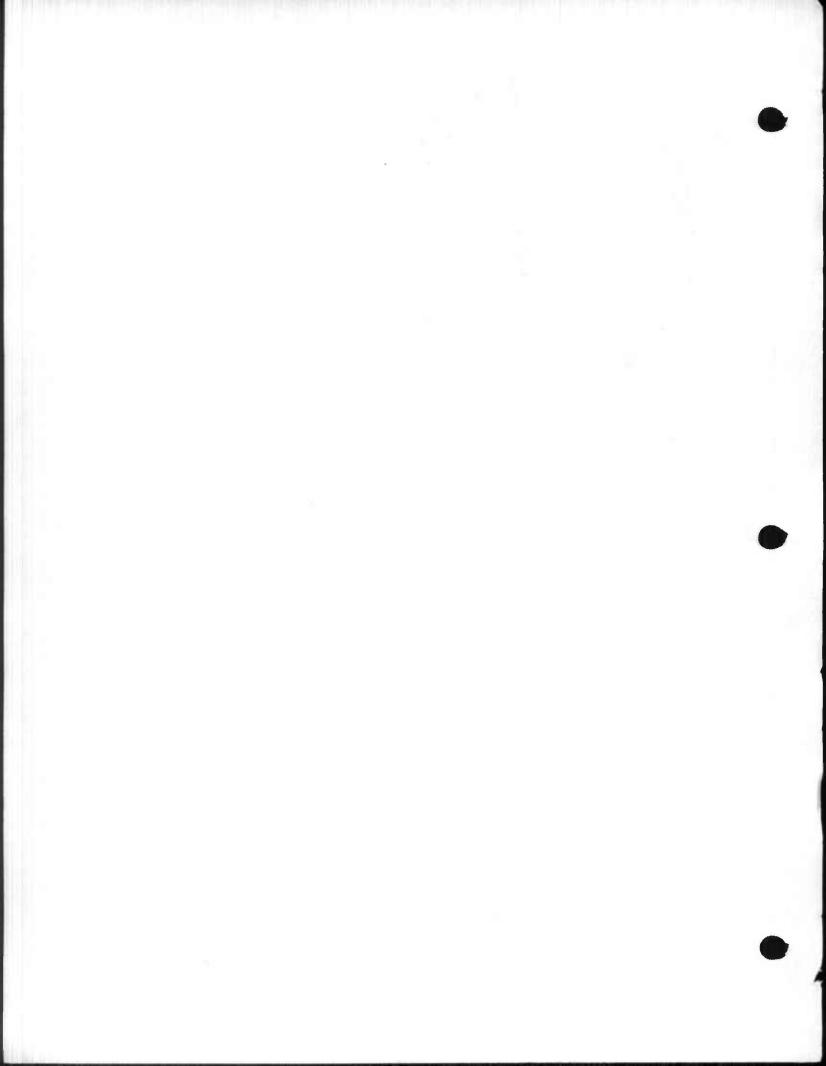
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

DHMH-16 Rev 1/89



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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U	U	3	0	U	U	0

Physician /Medical Examiner

Funeral Director

or 28a-f show Berrs 23a 8

permit. Pages 1 and 2 should be fial Department of Health and Mental Hy Important: If them 27 is mented oths any injury or other traumetic event

altimore, Maryland 21215-0020

Physician /Medical Examiner

attending physician and for use as the burial-transit The law requires that the deeth certificate be executed bengis lbe del Records, certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica in by

1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Dev Yeer Month 21, Gertie Viola Wallace 2000 Oct. 4:45 pm 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Death Tressler Lutheran Village at Harbor Point Salisbury Wicomico 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 10 M 2 F 820-04-2004 90 Sept. 8, 1910 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. fnslde City Limits 1 Yes 2 No Director Maryland Wicomico Salisbury 10e. Sfreet and Number 10f. Zip Code 10g, Citizen of What Country? 611 Tressler Dr., Apt. 205 21801 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 No Specify: Specify: p 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) William Riley Lewis Bertha Mae Dean 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Joan Wallace Davis/Daughter 34998 Poplar Neck Rd., Pittsville, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1X Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Dorchester Mem. Park 10-25 Cambridge, MD 21. Signature of Funeral Socioe Licensee 22. Name and Address of Facility
Curran-Bromwell Funeral Home, mulle 308 High St., Cambridge, MD 21613 Do not amer the mode of dying, such es cardiec or respiretory arrest, Approximete Intervel Between Onset end Death Immedieta Cause (Final disease or condition resulting in death) MESTIN Due to (or es a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Physician/Medical Due to (or es a consequence of): Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown Valvular Heart Disease à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 8 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 27. Menger of Death 28d. Describe how injury occurred 28b. Time of 1 Neturel 5 Pending 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 Sulcide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide edical 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.

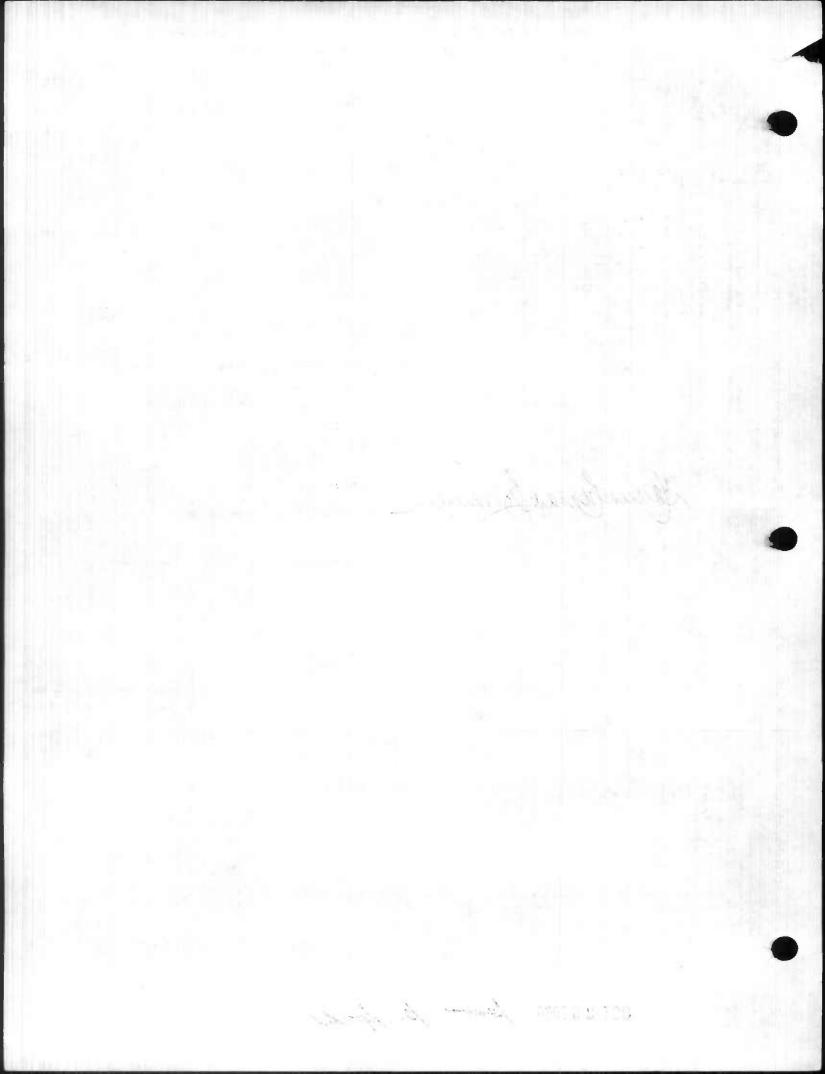
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10/24/00 21001 Minime and address of person who completed cause of deeth (Item 23a) (Type, Print) Pentertin Dr. Suite 2A, Salisbry M. JARRAIT, MD 32. Registrer's Signature LORRAINE 1201 31. Dete filed (Month, Day, Year)

DHMH 16 Rev 6/95

State

Registrar

OCT 2 5 2000

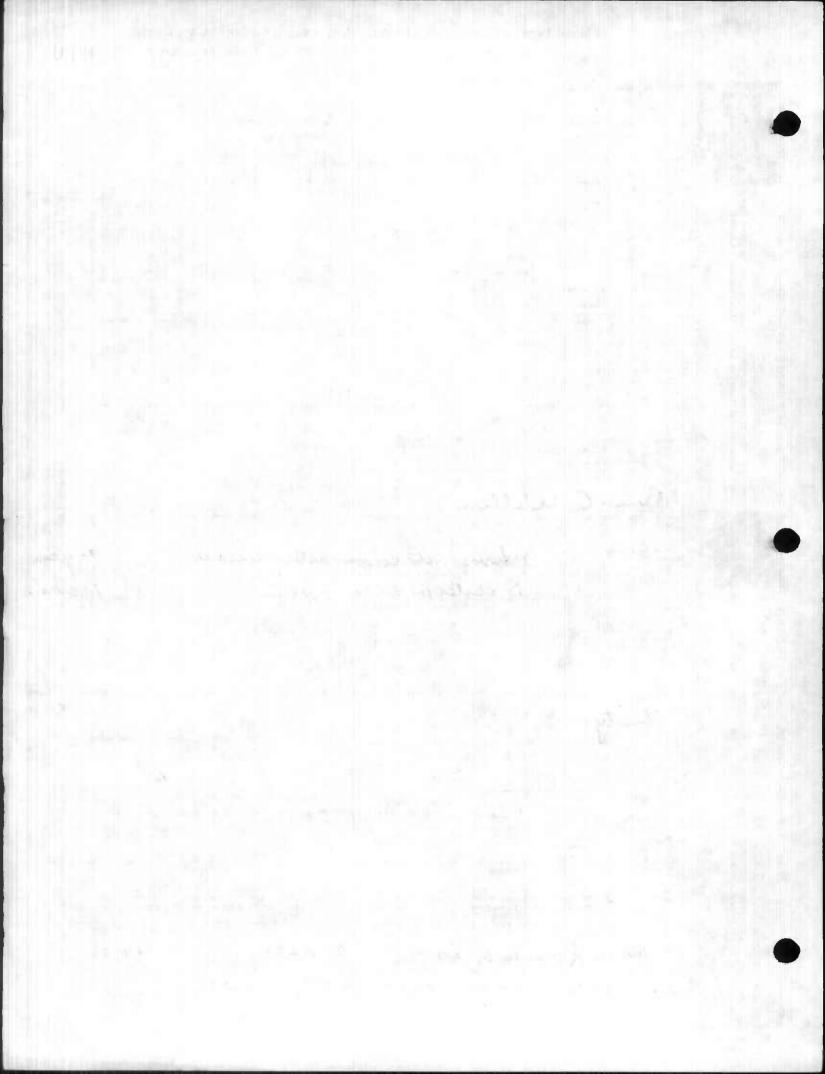


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 360 | 0

- Test				001	IIIIOU	16 01	Death			Reg. No.		
Physician	1. Decedent's Name (First, Middle, Las								2. Date of De Month	Day	Year	3. Time of Death
/Medical	Joseph A. But						4h City To		November cation of Deat		2 <i>000</i> y of Death	9:40 AM
Examiner	4106 Chardel Rd						Balti				ltimo	h o
Funeral Director	5. Social Security Number 6. Se	ex 7. Age	9 (In yrs. I 70	est birthday) Yrs.	If Under	er 1 Year s Days			8. Dete of Bir (Month, De July 5,			otace (State or Foreigntry) Yland
	Usual Residence of Decedent 10a. Stete 10b. County		10c City	, Town or Loc	cation							I 0d. Inside City Limit
at at a			TOC. Only		ultin	maka						1 ☐ Yes 2 🕱 N
or that a	Maryland Baltimo	re		Би		ip Code				10g. Citizen of	What Cour	
	4106 Chardel Roa	id, Apt. G				2	1236			u.	S.A.	yı
Standard must Examiner must by Funeral	11. Meritel Stetus 1 Never Married 2 Merrted 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 XN If Yes, Give Year or Dates:					dispenic Ori an, Mexicar Specify:		ocify Yes or No Rican, etc.)	Speci	ack, White,	can Indian, etc. hite
wer than "natural, the Medical.	15. Decedent's Ed (Specify only highest gra Elementery/Secondery (0-12)	fucation ide completed) College (1-4or 5	+)	16a. Deced (Give I life. D				t of worki	ng	16b. Kind of E		
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Be even	17. Father's Name (First, Middle, Last)									, Maiden Sume	me)	
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Departiment in particular in p	21. Signature of Funeral Servica Lican Buan C.	ville	ea.		970	5 Bel	lair R	?d.,	Home, Baltim	ore. MD	212	36
	23a. Part1. Enter the disease, or companies shock, or heart failure. List only	ptications that caused	the death									
		one ceuse on each lin	ine death	. Do not ente	er the mo	ode of dyli	ng, such as	cardiac c	or respiratory a	ırrest,		Approximate Intervat Between
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death W. Brown Agnes 2000 3:30 a.m. 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 3801 Schnaper Drive apt 128 Randallstown If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 M 201 F S.C. 250-14-7525 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21133 3801 Schnaper Drive apt 128 SA 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 [2] No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Merried Specify: Black 1 Tes 2NNo Specify: 3 ☒ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Professional Uniforms Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ray Williams Pearlie Lowery 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pikesville, Md 21208 4218 Red Haven Road Pearl Brown- Daughter 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 11-13-00 Owings Mills, Md Garrison Forest Veteran 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H West 4300 Wabash Avenue Baltimore, Md 21215 Marsh 23a. Part Enter that sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Diabetes Mellitus 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify)

Physician /Medical Examiner

Department of Important: If It any Injury or o

Physician

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Baltimore, Maryland 21215-0036

Examiner physician and the burial-transit Physician/Medical

98 certificate has b lirector, page 2 s

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Completed

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Certification:

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The law requires that the deeth certificate be axecuted or Attending Physician: After this

Division of Vital Records, P.O. Box 68760, To the Hospital or Atterwithin 24 hours after dea To the Funeral Director completely filled in by th

25. Was case referred to medical 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No

6 ☐ Could not be 3 ☐ Suicide 281. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifier alexanders

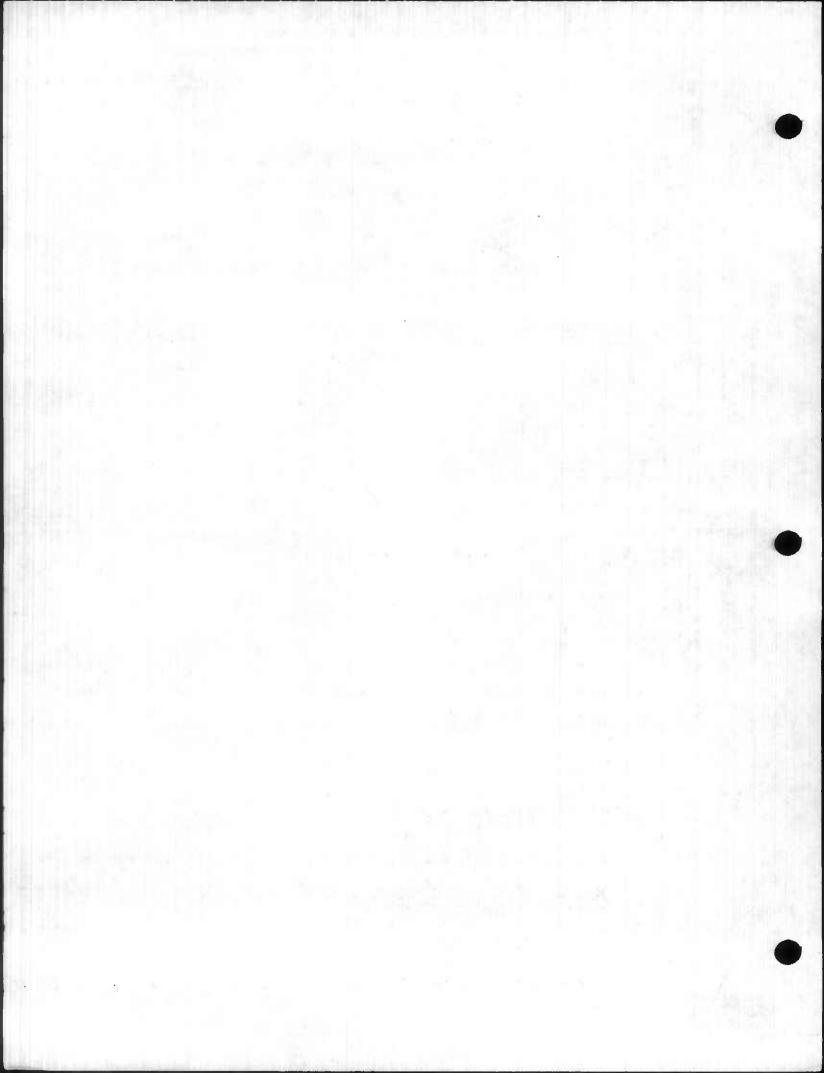
29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARLAS, ALEXANDER, MD 29 S. 29 S. greene St. Svite 300, Baltimore, md 2/20/ 31. Date filed (Month, Day, Year) 32. Registrar'a Signature

State Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month JOSEPH V. BRECHT 8.55 PM NOVEMBER 09 2000 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL BALTIMORE CENTER If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months 10M 20 F 34 Yes 218-74-3601 March 15 1966 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits Baltimore Anne Arundel Co. 1 Yes 2 No 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? USA 21225 4212 Belle Grove Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Specify: White 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) not applicable 12 Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Nancy Lee Ohlverter John Louis Brecht, Sr. 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4212 Belle Grove Road, Baltimore, Md. 21225 19a. Informent's Name/Relationship (Type, Print) Catherine C. Brecht (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 Donefion 5 Other (Specify) Cedar Hill Cemetery 11/13/2000 Baltimore, Md. 21. Signature of Juneral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death IWEEK Immediate Cause (Final SEPSIS disease or condition resulting in deeth) Due to (or as a consequence of): 2 WEEKS HEPATIC ENCEPHALOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 2 WEEKS PNEUMONIA Due to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior fo completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes

Physician /Medical Examiner

Physician

/Medical

Examiner

Md.

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Funeral

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Completed

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altimore. Maryland 21215-0020

Box 68760.

P.O.

Division of Vital Records.

2 should be fi and Mental H is marked of

Department of Health an Important: If Nem 27 is a any Injury or

Examiner Physician/Medicai P Completed Be 2 Certification:

physician and s the bunal-transit 3 be de this after death.

Director: After d in by the funer Hospital or 24 hours after Funeral Directory filled in b

25. Was case referred to medicat axaminer? 1□ Yes 2□ No

27. Manner of Death 11 Natural 5 Pending investigation 2 Accident 3 ☐ Suicide 4 Homicide

6 Could not be

Hospitel: Inpatient 28a. Date of Injury (Month, Dey Year)

2 ER/Outpatient 3 DOA 28b. Time of

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier, turzael

29c. License number 13474

29d. Date signed (Month, Day, Year) NOVEMBER 09 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAJIDI 3001 SOUTH HANOUER STREET, BALTIMORE, MARYLAND 21225 31. Date filed (Month, Day, Year)

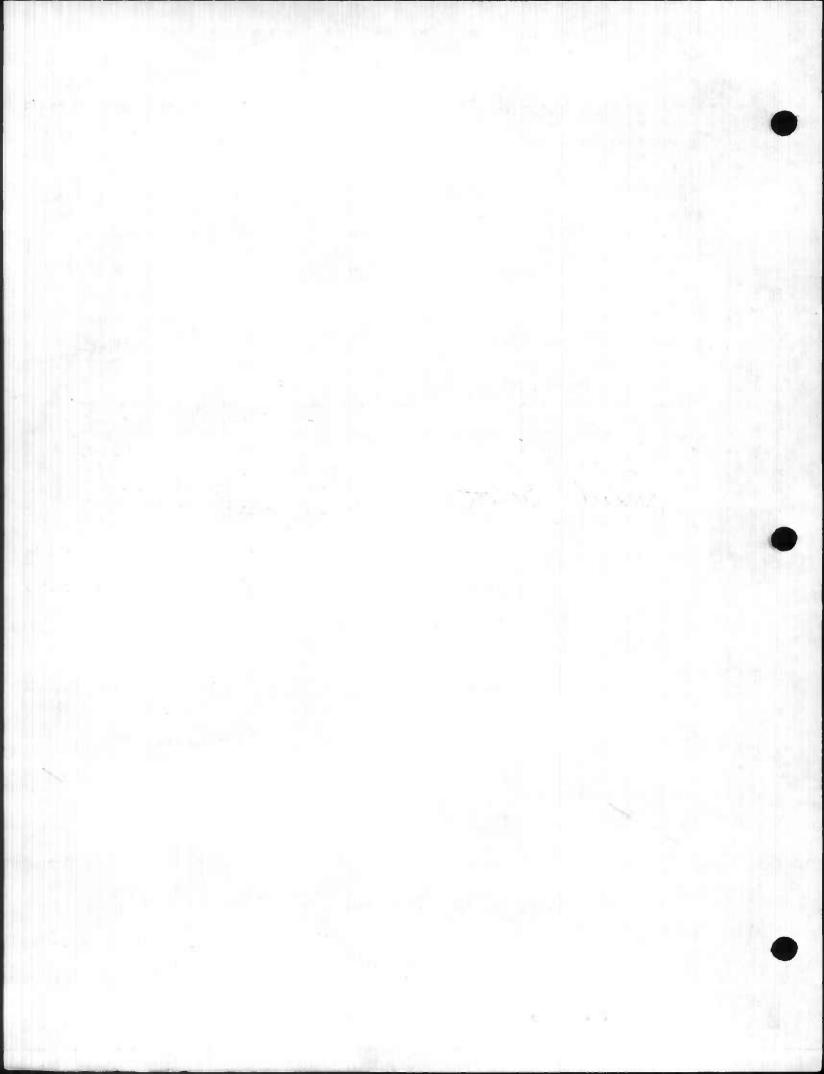
Registrar

Medical

29a. Certifier

32. Registrar's Signature NOV 14 2000

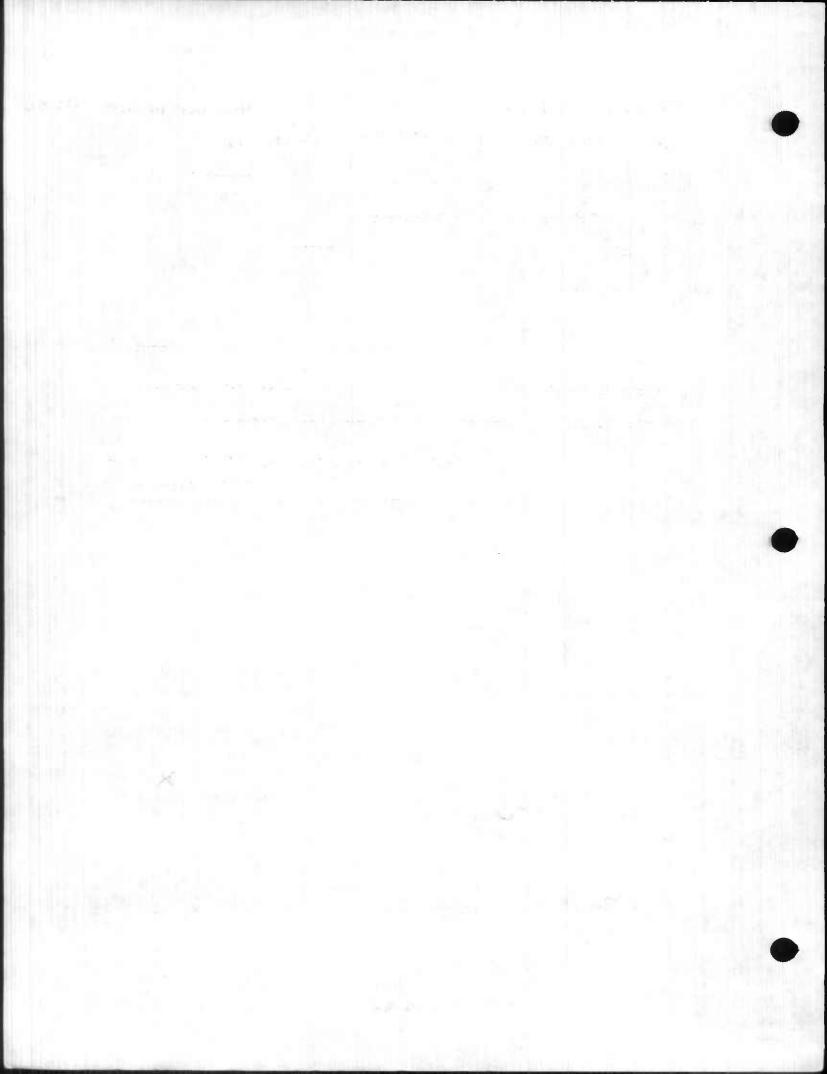
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State of Maryland / Department of Health and Mental Hygiene 00 360 | 3

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/Medical Examiner		Facility Name (if not institution, g	ive street and number)					b. City, Town	n, or Location	of Death	4c. County		
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Funeral Director	2	217-50-3256 uat Residence of Decedent	1□ M 2□ДF	54		Months		Hours	Min. (A	ate of Birth fonth, Day, 1	(ear) 2,1946	Count	MD
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or the	11.	Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 Y If Yes, Give Year or Dates:	7 - 111 - 1			edent of Hecify Cube	ispanic Origi on, Mexican, Specify:	n? (Specify) Puerto Ricar	es or No- , etc.)			tc.
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is ma		a. Informant's Name/Relationship					1				City or Town,		
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Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, the Manage. To Be Comp	201	a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special Control of		CE	lace of Dispo emetery, cren 15 Roa	netory or	other plac		em l 11		oc. Location - Bu	City or Tov	
Department Important: If any Injury or once.	21	. Signeture of Funeral Service Lie	ensee	2	22	2. Name	ind Addre	ss of Facility	118	24 Rei	sterst	own R	oad
	- 24	Part1. Enter the disease, or cor	1-00	d the death				ral Ho					MD 21136 Approximate
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

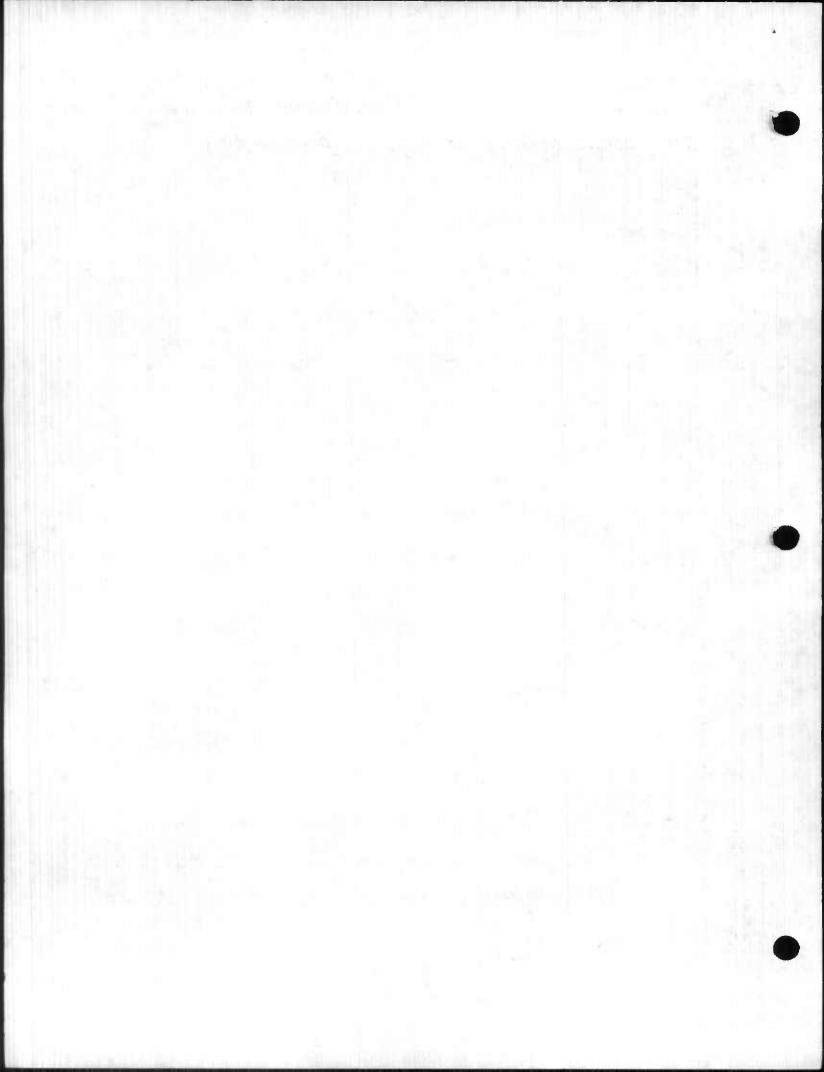
Reg. No.

3601

		Cer	rtificate of	Death	Re	g. No.	30014
	Decedent's Neme (First, Middle, Last)		0		2. Deta of Death		3. Time of Death
Physician /Medical	ANNA	[SONEN	SERGER	Novemo	ER 102	Classic committee
Examiner	4e Facility Neme (If not institution, give street and number)	1		4b. City, Town, or L		4c. County of	Death
	THE JOHNS HOPKINS H	PSPITA	6	BALTIMON	ECITY	N/A	1
Funeral	1 FPA 44 TF	yrs. last birthday)	Months Deys	If Under 24 Hrs.	8. Date of Birth (Month, Day,	Year) 9	Birthplece (Stata or Foraign Country)
Director	161 24 4659 1□M 2♥F 73	3 Yrs.			July 30,	1927	Pennsylvania
P .	Usuel Residence of Decedent 10a. Stete 10b. County 10c.	. City, Town or Lo	reation				10d. Inside City Limits
ahou aho		Baltimor					1 S Yes 2 □ No
hours after death with the Manyland brail, or thems 23s or 28s-f ahow at Edina at must be modified at ed by Funeral Director		Dalcimor					
vith the Ma t or 28s-f a be notified	10a. Street and Number		10f. Zip Code		11	g. Citizan of Wh	at Country?
vurs after death with the Marylan all; or flems 23s or 28s-f show Examiner must be notified at by Funeral Director	611 Annabel Avenue		212			U.S.	
r Hems 23s	11. Marital Status 12. Was Decedent Ever in Armed Forces?	n U,S. 13.	Wes Decedent of If Yes, specify Cul	Hispanic Origin? (Sp ben, Mexican, Puerto	Decity Yes or No- Dican, atc.)		Amarican Indian, White, etc.
L'ort	1 Never Married 2 Merried 1 Yes 2 No		1□ Yes 2⊠ No	Specify:		Specify:	White
natural', ndret En	3 Widowed 4 Divorced Year or Detes:	10.0	1 11 10			Ob Mind of Duni	
ygiene. her than "naturn rt, tre Medical Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occu kind of work done	pation during most of work ed)	king	16b. Kind of Busi	ness/industry
r than nat re Medic omplete	Elementery/Secondery (0-12) College (1-4or 5+)		retarial			Farm Su	nn1ios
	17. Father's Neme (First, Middle, Last)	Sec	.ietaiiai		ne (First, Middle, A		
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umatic To							
2 4	19e. Informent's Neme/Relationship (Type, Print)			ot and Number or Ru			
f Health itam 27 other tr	Robert Bonenberger / Son 20e. Method of Disposition 20	b. Plece of Dispo	Kennedy	Street			aryland 20781 ity or Town, Steta
5 = 0	1 Burlal 2 Cramation 3 Removal from Stata	cemetery, crer	matory or other pla				a labour of the
Department important: If any Injury or pace.	4 □ Donetion 5 □ Other (Specify) B	ayview (Crematory	y, Inc.	1/16/00	Baltimo	re, Maryland
Department mportant: any injury ance.	21. Signature of Funeral Service Licensee	22	2. Name end Addr	ess of Fecility	Gonce Fu	neral Ho	ome P.A.
20119	Janus Minamuseu	2/1/40	001 Ritch	nie Highwa			
	23a. Pert1. Enter the disease, or an uncations that caused the dishock, or heart failure. List on the cause on each line.						Approximete Interval Between
hysician	SHOCK, OF HEAR TARDER. LISTON COURS ON GOOD MILE.						Onset and Deeth
/Medical	Immediate Cause (Final disease or condition resulting in deeth)	DY F	manis.	M .			OUT WEEK
xaminer	resulting in deeth)	to (or es e consec	guence of):	71			TOPE OF CET
je je	- MULTIPLE	5 MUGT	AMA				3 MONTHS
physician and street the burial-transit		to (or es e consec					
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury						
physicisms the bu	thet initieted events	o (or es e conseq	quence of):				
0 6	rasulting in death) Last						
attending physician and for use as the bunal-transit clan/Medical Examir	d						
gned by the attend be detached for us by Physician/	Part It. Other significant conditions contributing to death but not	resulting In the u	inderlying cause g	iven in Part I.	23b. Did to	bacco use contr	ribute to the cause of death?
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signed by De det					, , ,	apetitio -	
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has ge 2					V		1.4
r. page					1 X Y		1 ☐ Yes 2 No
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or death. Setor: Afte by the fune	2 Accident investigation 3 Suicide 6 Could not be			Yes 2 No			
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on the Funeral Direct on pletch filled in by Medical Certifi	end menner steted.						
Med Med	29b. Signature and title of pertifier	71117	29c. Licar	nse number	2	9d. Date signed (Month, Day, Year)
10	(aurothou //	1.0.	DL	17287	1	LOVEMBE	R 10, 2000
110	30. Name and address of person who completed cause of deeth (Print) CA	COL ANI	HUAC.	M.D.	(Month, Day, Year)
)	600 NORTH WOLFE SMEET		MORE!	MARYIA	ND2128	7	
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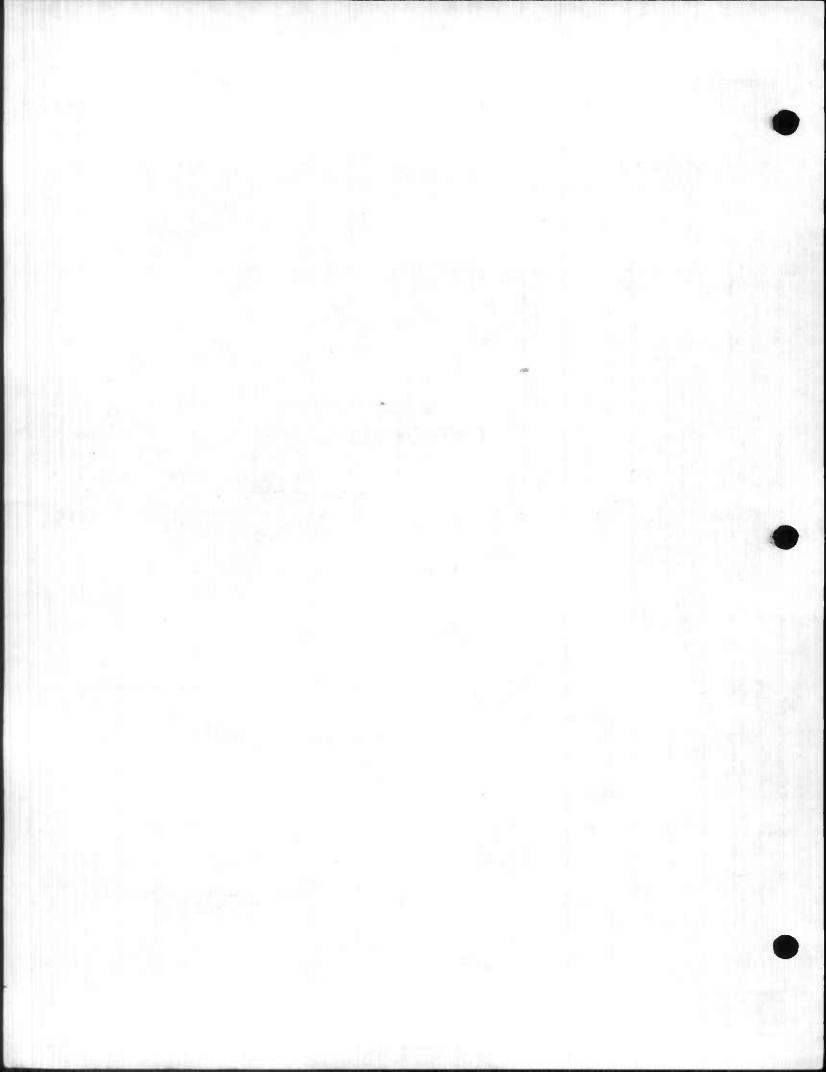
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	Decedent's Nama (First, Middla, L.	nst)	Certif	ficate of	Death	2. Date of Dec	Reg. No.	36015
Physician	Erwin	Ber	ger			Novemb	Day	Year
/Medical Examiner	48 Facility Nama (If not institution, gi Northwest Hosp	va street and number)			4b. City, Town, or Randal	Location of Death	4c. County	
Funeral Director	5. Social Security Number 138–24–5671		M	Under 1 Year lonths Days		8. Data of Birt (Month, Da APR	20, 1933	9. Birthplaca (State or Foreign Country) PA
pur .	Usual Residence of Decedent 10a. Stata 10b. County	10c. C	City, Town or Locati	on				10d. Inside City Limits
uth with the Marylan 23s or 28e-f show ust be notined at rel Director	MD BALTIM		WINGS MIL					1 ☐ Yas 2 🕅 No
vith the Mar t or 28s-f a be notified Director	10e. Street and Number	0.1.2		10f. Zip Code			10g. Citizen of W	/hat Country?
H with	3 BARONESS COURT				21117		U.S	.A.
or hema	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☑ Yas 2 ☐ No If Yes, Give Year or Dates:		Decedent of I es, specify Cub Yes 2 No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Race Blace Specify.	e - American Indian, k, Whita, etc. White
ed within 72 ho ygiene. er than "netur t, the Medical Completed	15. Decedent's E	ducation ada completed)	16a. Decedent	's Usual Occup	pation during most of wo	rkina	16b. Kind of Bu	sinass/industry
	Elementary/Secondary (0-12)	College (1-4or 5+)	lifa. DO	NOT use retire	d)	E 4/4	T AM ENTE	ND CEMENT
	17. Father's Name (First, Middle, Last	22	POLICE	OFF ICE		me (First, Middle,		ORCEMENT
Mental H Mental H arked oth	SAMUEL	,	BERGER		LILLIAN		ZELDA	OSTROW
nd 2 should be file ith end Mental Hy 77 is marked other traumatic event	19a. Informant's Name/Relationship ROSALIE BERGER				and Number or R			
of Hear of Hea	20a. Mathod of Disposition 1 Surial 2 Cremation 3 [4 Donation 5 Other (Speci	Removal from Stata	Place of Disposition cometary, cremator	ory or other pla		Data 11/10/0		City or Town, Stata
pemit. Pag Department Important: I any Injury o	21. Signature of Funeral Service Lice	**		ama and Addre	20	OL LEVIN	SON & BR	OS., INC. E, MD 21208
Physician	23a. Part L. Enter the disease, or con shock, or heart failure. List only	programme that claused the decome cartine on each line.	1					Approximate Interval Between Onset and Death
/Medical Examiner	Immediata Causa (Final disease or condition rasulting in death)	a. Sepsis	(or as a consequen	no off.				1 day
D =		Preumo						days
cate be executed physician and s the buriel-transit	Sequentially list conditions,		(or as a consequen	ice of):				
ficate be ex physician as the buriel edical Ex	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury	clung c	ancer					1 year
1 00	that initiated events resulting in death) Last	Due to	(or as a consequen	ce of):				
attending for use						1		1
ras that the death certisioned by the attending to be detached for uses a by Physician/M	Brain metast		sulting in the under	rlying ceusa gi	ven in Part I.			atribute to the cause of death? 3 □ Probably 4 □ Unknow
The lew requires that the death certained has been signed by the attending page 2 should be detached for use Completed by Physician/N							an autopsy med?	24b. Were autopsy findings available prior to completion of cause of death?
The le						101	ras 2 No	1 Yes 2 No
sicient: The lew is certificate has build lifector, page 2 along o Be Comple	25. Was case referred to medical				26. Place of De	ath (Check only o		13.00 23.00
	axaminer?	Hospital: 12 Inpatient 2	☐ ER/Outpatient :	3 DOA O	or .	Homa 5□ Resid		ar (Specify)
Attending Physical death. ector: After this by the funeral di	27. Manner of Death 1 Natural 5 Pending 2 Accident Invastigation	28a. Date of Injury (Month, Day Year)	28b. Time of tnjury	28c. tnju Wo M 1	ry at rk? Yes 2 □ No	28d. Describe I	now injury occurr	ed
tal or Attending P rs after death. al Director: After led in by the funer: Certification:	3 Suicide 6 Could not be determined		home, farm, street,	factory, office		28f. Location (S City or Tox		er or Rural Routa Number,
Hospi 4 hours funer taly fill	29a. Certifier 1 Certifying PI (Check only one)	nysician: To the best of my kn miner: On the basis of axamin and manner stated.	nowledge, death och nation and/or investi	curred at the ti igation, in my o	me, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and ma date and place, a	nnar as stated. and due to the cause(s)
To the Comple	29b. Signature and titla of certifier			29c. Licens				i (Month, Day, Year)
Q.	DRoggen				5844	/	Novembe	r 09 2000
210	Droggen 52	completed cause of death (Ne	om 23a) (Type, Prin cl Ranc	dells to	un mo	21133	3	
State Registrar	31. Data filed (Month, Day, Year)	32. Registrar's Sign	- K2	Room	100			

DHMH 16 Rav 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death 8, 2000 **Physician** Month NOV Lillian Strobel Chaney 6:40pm november 8200 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore** Gilchrist Center Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JAN. 16, 1926 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (Stete or Foreign **Funeral** 10 M 20 F Months Days Hours Maryland 218-22-9619 74 Yrs. Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes & No Director Baltimore Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 USA 5 Erwood Court Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 t. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ₺ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Real Estate Manager 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Edgar Randolph Strobel Lillian Linthicum 19e. informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Ernest Lawrence Dinning, IV/son 908 West Baker Avenue Abingdon, MD 21009 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Buriei 2 【Cremation 3 ☐ Removei from Stete 11/9/00 Metro Crematory, Inc. Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Ligender

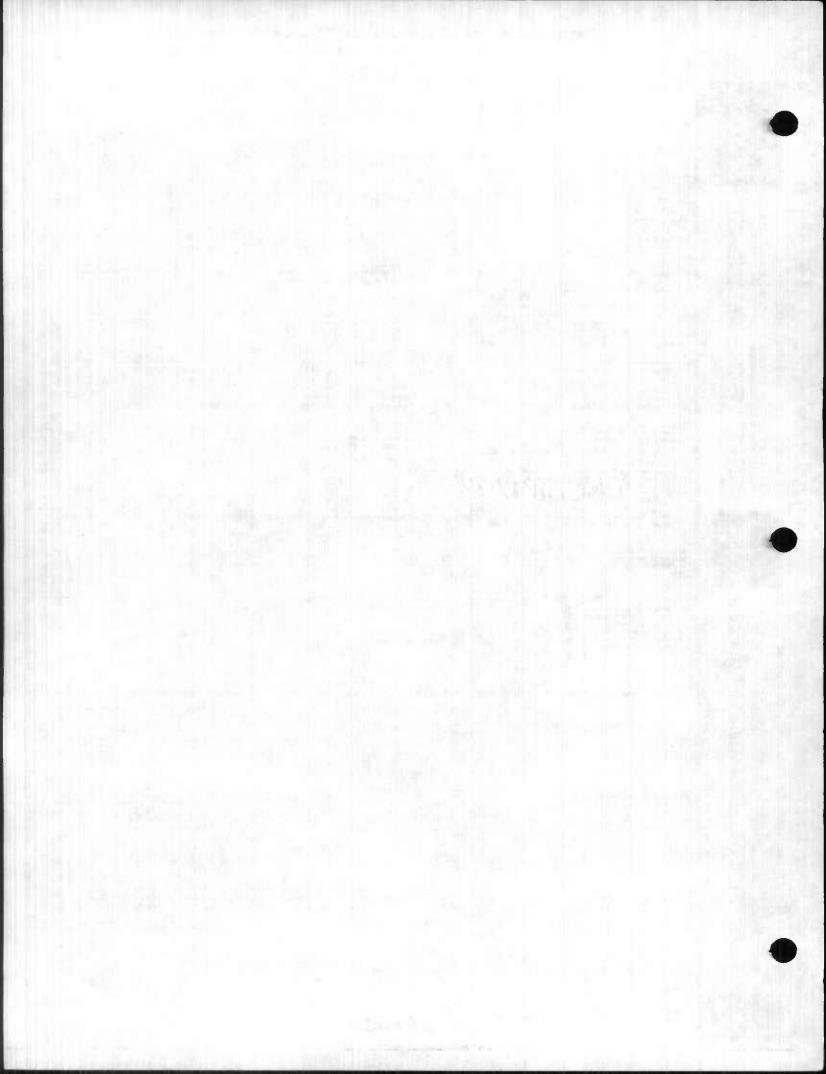
Dawn F. McDonald Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Physician Breast Concer Immediate Cause (Final disease or condition resulting in death) /Medical care Examiner Physician/Medical Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated expects.) Due to (or as a consequence of): Box 68760. that initiated events resulting in death) Last Due to (or as a consequence of) P.O. 23b. Did tobacco uss contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Records, Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy 2 No 1 □ Yas 2 □ No of Vital 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division or Attanding 1 Naturai 2 Accident 5 Pending investigation after death.

I Director: Af in by the fu 1 Yes 2 No 28l. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Within 24 hours Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated. 29e. Certifier Medical å 29d. Date signed (Month, Day, Year) 29b. Signeture and title of Certifie 29c. License number , mo ed cause ol death (Item 23a) (Type, Print) N. Charles St. Balto. md GB/m C 31. Date liied (Month, Day, Year) 32. Registrar's Signature State NOV 1 4 2000

DHMH 16 Rev 6/95

Registrar

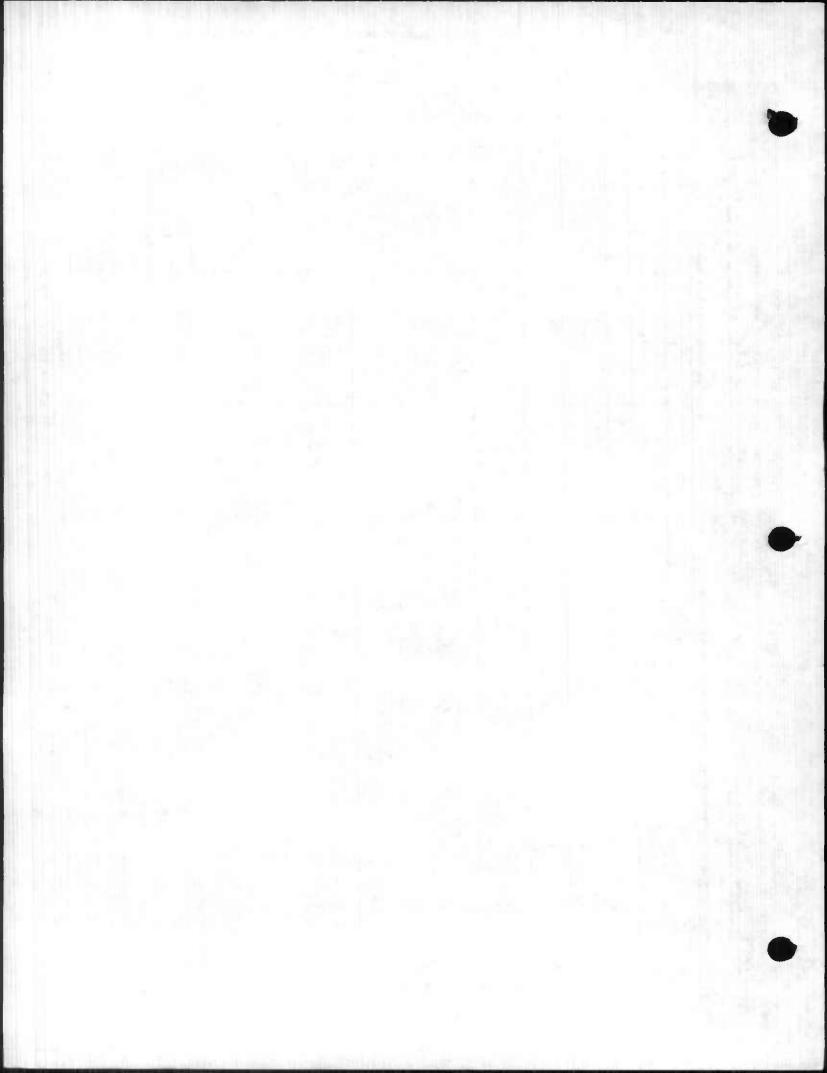


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State of Maryland / Department of Health and Mental Hygiene

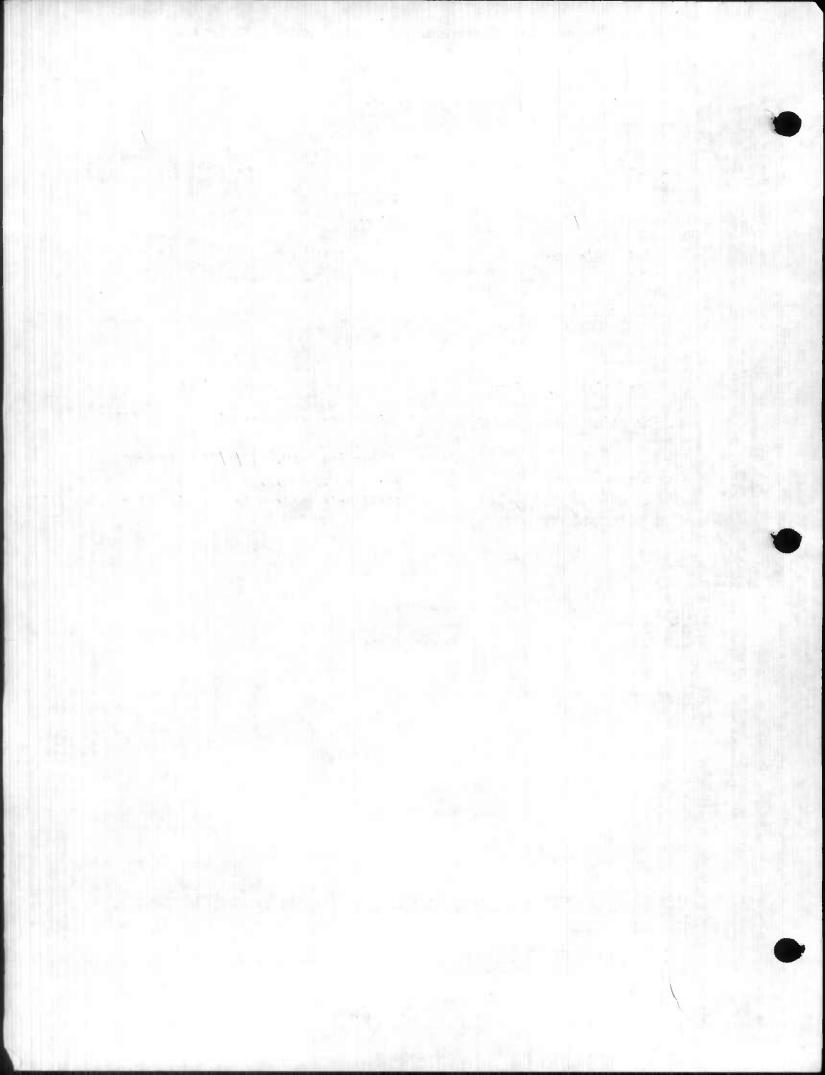
				Certifica	te of D	eath		Reg. No.	3	6017
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Physician /Medical	ETHEL		COUGH	LIN			NOVEMBO		2000	07:00 A
Examiner	4a Facility Name (If not institution,			30 V			Location of Death	4c. County o	of Death	
	HARBOR HOSPIT							N/		
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natural; or flams 23a or 28a-f ahow final Examiner must be notified at steed by Funeral Director	Usuel Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location					11	0d. fnaide City Limi
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r hems 234	11. Marital Status	12. Was Decedent	Evar in U,S.	13. Wes Dec	edent of His	penic Origin? (S	Specify Yas or No- to Rican, etc.)	14. Race		an Indian,
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nent of Hea int: If Item 2 iry or other	20a. Method of Disposition 1 Durial 2 Cremetion 3 4 Donetion 5 Other (Spe		cemete	f Disposition (N ry, cremetory or Hill C	r other plece,		11/13/00	20c. Location - (wn, Stete Maryland
Department Important: h eny injury o phos.	21. Signeture of Funerel Service Li	censee	/		end Address			uneral F		
	(Juna)	France	rouse	1			ay Balt		2C - 2	Approximete
	23a. Pert1. Enter the diseese, or c shock, or heart feilure. List o	nly one cause on each l	line.	not enter the m	oda or dying.	, such es cardie	c or respiratory ar	1051,	1	Intarvel Between Onset end Death
iysician Medical	Immediate Cause (Final			0.0	4 40	. 4 7			1	
caminer	Immediate Cause (Final disease or condition resulting in death)	· INTES	TINA	- OB	STRI	JC 110.	N	8-1-1	- 1	+8 HOUR
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nsit		b. 7KU131	MBLE			17 01	e colc	IN	1	
in and ial-transit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	1	Due to (or es a						1	
g physician and as the burial-transit	Cause. Enter Underlying Ceuse (Disease or injury that initiated events	c. LIVE		7A ST.					1	
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e attending physician and od lor use as the bunal-transit sician/Medical Examir	Paragolia de la constante de l	d								
2 6 2						7/ 51				
ed by the a detached I	Pert If. Other significant condition	a contributing to death I	but not resulting i	n the underlying	cause giver	n in Pert I.				the cause of dea
dete P							10	Yas 2□ No	3 Prot	bably 4 Unkr
D 20		11.					24a Was	an autopsy	24b. W	ere autopsy findin
page 2 should							perfo	med?	av	ailable prior to mpletion of cause
has by ge 2 s								/	of	death?
page Com							10	Yes 212 No	1.0	Yes 2 No
= 6 6	25. Wes case referred to medical examiner?						eth (Check only o	one)		
this certified direct	1 Yes 2 No	Hospitel: 1 Inpati				4 LI NUISING I	dome 5 ☐ Resid			y)
After the funeral funeral tion:	27. Manner of Death 1 ☑Neturel 5 ☐ Pending	28a. Dete of Inj (Month, Da	ay Year) 28b.	Time of Injury	28c. fnjury Work		28d. Describe I	how injury occurre	ed	
aftar death. Director: After I in by the fune	2 Accident investiga	the l		М		es 2 No				
= 40	3 Suicide 6 Could no determin	ad 289. Place of In	ijury - At home, fe dc. (Specify)	erm, streat, fecto	ory, office		28f. Location (S City or Tox	Street and Numbe vn, State)	ar or Aure	el Route Number,
C e e										
Within 24 hours after To the Funerel Direction of the Funerel Direction of the Funerel Direction of the Funerel Medical Cert	29e. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best caminer: On the basis of and menner s	of examinetion an							
M Com	29b. Signature and title of certifier	0 -		2	9c. License	number		29d. Date signed	(Month,	Day, Year)
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41	30. Neme end addresa of person w		M D	1.	, , , , ,			.0.01010		1 -000
76	Day Asses				11710	3001	HANOVE	R STEET	T DI	WILLANDE
	31. Date filed (Month, Day, Year)	M), HARBI	rar's Signeture	I'ML UE	10101	, 5001 3	MINORE	. TOTALE	101	UTTOTORE
State Registrar		000	A STATE OF THE PARTY OF THE PAR	9 14	ocker	/ -				
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36018

5. 2	Sheri a Facility Nama (It not institution, give st	Lee	Cough	20		Month	7 Day	Year	
er ⁴⁸ 5. 2				-6		NOV.	7, 2000		0930 A
2		reet and number)			4b. City, Town, or L BALTIM				
2	1013 UNION AVENUE		food foliabledous) If II	Indar 1 Year	If Undar 24 Hrs.		N/		(State of For
	.13-78-7097	7. Aga (In yrs. 35		nths Deys	Hours Min.	8. Date of Birt (Month, Day Sept 14	y Year) 4, 1965	9. Birthpii Count Mar	ece (Stete or For ry) Lyland
-	Sual Residence of Decedent Oa. State 10b. County	10c. Ci	ty, Town or Location					10	d. tnaide City Lin
	Maryland N/A		Baltin	none.					1X Yes 2□
-	0e. Street and Number			f. Zip Coda			10g. Citizen of W	hat Count	ry?
	1013 Union Ave	enue		212	11		u.s	.A.	
11	1. Meritel Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	2. Was Decedant Evar in U Armed Forces? 1 ☐ Yes 25 No If Yes, Give Yaer or Detea:	If Yas,	Decedent of H specify Cubi es 21 No	dispanic Origin? (Sp an, Mexicen, Puerto Specify:	ecify Yes or No Rican, etc.)	Specify:	- Americe k, White, e	en Indian, itc. ite
	15. Decedent's Educi (Specify only highest grade Elementery/Secondery (0-12)	etion com <i>pleted)</i> College (1-4or 5+)	16a. Decedent's (Give kind of life. DO No	Usuel Occup of work done OT usa ratire	during most of world	king	16b. Kind of Bu	siness/Ind	ustry
47	7. Father's Name (First, Middle, Last)	-0-			18. Mother's Nem	o /First Middle	Maidan Sumam	0)	
	Frederick L.	Dixon				bara Wi		-/	
1	19e. Informent's Neme/Reletionship (Typ		19b. Meiting Add	dress (Street	end Number or Ru			State, Zip	Code)
٨	Wr. Frederick Dixor	r Father	3844 Nic	cholso	n Road U	estmins.	ter, MD	2115	7
20	0e. Method of Disposition		Plece of Disposition	(Neme of or other pla	ce)	Date	20c. Location -	City or To	wn, Stete
	1 ☐ Burlel 2 ② Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		urroll Cre			11/8/00	Hampst	tead,	MD
2	21. Signeture of Funeral Service Lightney		22. Nan	na and Addre	eral Home				
	16/1/2	May ?			sterstown		Reisters	town	, MD 211
d	mmediete Cause (Finel disease or condition a.	NARCOTIC INTO	XICATION or es e consequence	e of):		100			
o C	Gequentially list conditions, fany, laeding to immadiate cuse. Enter Underlying Cause (Disease or Injury	Due to (or es a consequence	e of):					
	hat initiated events esulting in death) Last	Due to (c	or as a consequence	e of):					
P	Part II. Other eignificant conditions cont	ributing to death but not re-	sulting in the underly	ing couse of	ven in Pert I	23h Did	tobacco uee cor	tribute to	the cause of de
-	arti. Other agricult conditions con	nouning to death out not res	suking in the underly	ning couse gi	VOIT WET OIL 1.		Yes 2 No		nably 4 💢 Unk
_							an autopsy ormed?	ava con	ere autopsy findinaliable prior to mpletion of ceusadeath?
						1周	Yes 2□ No	1/2	Yes 2□ No
2	5. Was case referred to medical examinar? 1 ⊠ Yas 2 □ No Ho	ospitel: 1 Inpatiant 2	ER/Outpatient 3	DOA Oti	26. Place of Dec		one) dance 6x2Oth	er (Specif)) AT SCI
27	7. Menner of Death 1 Naturel 5 Pending 2 Accident investigation	28e. Dete of Injury (Month, Dey Year) 11/7/00	28b. Time of Injury unknown M	28c. Inju Wo 1	ny et rk?] Yes 2 ∑ No	unknown	how injury occurr		
	3 ☐ Suicida 6 ☐ Could not be determined	28e. Plece of Injury - At h building, etc. (Speci found: Resid	nome, farm, street, foi fy) lence	ectory, office		28f. Location (City or Tor Baltimor	Street end Numb wn, Stata) 101 e City, Ma	l3 Uni	on Avenue
2		clan: To the best of my known: On the basis of examine and menner steted.							
2	9b. Signeture end title of certifier	1		29c. Licens	se number		29d. Dete signe	d (Month, i	Day, Year)
	Atysh A O. Neme and address of person who con	Vlada	M. A. Print		C.M.E		NOV.	8	,2000



State of Maryland / Department of Health and Mental Hygiene

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					Ce	rtificate	e of	Death			Reg. No.	10 .	36019
Physician //Medical	1. Decedent's Name (First, Middle, La	st)			COHE	N			2. Dete of De		200 9 ar	3. Time of Death 5:51PM
Examiner	4a Facility Name (If n	BALTIM			CENTER		- 1	BALTIM	ORE	ocation of Deat		Inty of Death	
Funeral Director	5. Social Security Nun 064-05-2	832	Sex XIM 2□F	7. Age (In yrs. 83	last birthday Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Dete of Bi	1917	9. Birth NEW	piece (State or Foreign intYORK
the Meryland 28a-f show northed at	MD	ob. County BALTIMOR	E		ty, Town or LALTIMOR								10d. Inside City Limits
ifer death with the Menyland if thems 23s or 28s-f show other must be notified at Euroaral Director	10e. Street and Numb		рт. 3			10f. Zip	Code 208		ň		10g. Citizen USA	of What Cou	intry?
	3 ☐ Widowed 4	I 2		2 No	J,S. 13.	Was Deced	ent of I	en, Mexicar	gin? (Spo i, Puerto	ecity Yes or No Rican, etc.)		fcan Indian, , etc.	
filed within 72 hours after the Wygiene. The "natural", or the then "natural", or the the world and the First Communicated by First	(Specify Elementary/Second	5. Decedent's Ed only highest gra lary (0-12)	ducation de completed) College (1-4or 5+)	(Give	DO NOT us	k done e retire	during mos		ing HASING	16b. Kind o	f Business/le	ndustry
d a d	17. Father's Neme (Fi	irst, Middle, Last,)	COI	HEN			18. Mothe MARY		8 (First, Middle	, Maiden Sun	name) WIN	ICK
of Health end I item 27 is m r other treum	19a. Informant's Nam MRS DORIS (20a. Method of Dispos 19a Donation 5	COHEN/WI	FE Removel from	State OHE	10 PO	MONA S	I'UO	H APT	. 3	BALTIMO Date 1/12/00	ORE, MI	on - City or I	O8
Department of I Important: If He any Injury or o price.	21. Signature of Fune		nsee					ess of Facilit	SO	L LEVIN			INC. . 21208
Physician /Medical Examiner	23a. Pert1. Enter the shock, or heart if the shock is the shock in the shock is the shock in the		plicetions that cone cause on e	caused the dee	vie	quence	o of dyi	lu	cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
certificate be executed formal viding physician and use as the burial-transity.	Cause (Disease or in) that initiated events resulting in death) La	ring jury	b		or es a conse	m	el.	anc	er.	2			20 years
ed by the ettend detached for us	Part II. Other algorifica	ant conditions o	contributing to d	eath but not res	sulting in the	underlying ca	iuse gi	ven in Part I	I.	23b. Did	tobacco use	contributa	to the cause of death?
should be detact		71 - 51 - 51 - 51 - 51 - 51 - 51 - 51 -	-				_				Yaa 254		obably 4 Unknown
5 C/										perf	s an autopsy ormed?	0	Vere autopsy findings available prior to completion of cause of death?
s certificate hi director, page To Be Corr	25. Wes case referred	d to medical						26. Place	of Deet	h (Check only	one)		
hysic li dire	1 Yes Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home									ome 5 Res 28d. Describe			HOSPICE
or Att	3 Suicide 4 Homlcide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)									(Street and Nown, State)	umber or Ru	ral Route Number,	
To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	(Check only 2	Certifying Ph Medical Exam	niner: On the b			nvestigation,	in my	opinion, dee			, date and pla	ica, and due	to the cause(s)
withi Form	30. Name and vidres	duy l	ull completed caus	Unill	1D m 23a) (Type	1	Licen	se number	99		/	gned (Month	n, Day, Year)
State	31. Date filed (Month,	ducy	Willi	awy Aegistrar's Sign	MD,	6 B	NI	c, B	AL	7/40/	16		
State Registrar	M	01/40	0000	6	w)	4	1	11					

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State of Maryland / Department of Health and Mental Hygiene 0 36020

	Cert	ificate of Death	Re	eg. No,	001.0
	Decedent's Neme (First, Middle, Last)		2. Date of Deat	Day . Veer	3. Time of Death
hysician Medical	Harriet Ethel Divel		Novembe	x 11 2000	2123
xaminer	4a Facility Neme (If not institution, give street and number)		or Location of Death	4c. County of Deeth	
	Washington County Hospital	Hagers		Washingt	
neral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) 212-30-6553 1□ M 2√F 6.7 Yrs.	Months Deys Hours	Hrs. 8. Dete of Birth (Month, Day,	Year) 9. Births	plece (Stete or Fore ntry)
ector	212-30-6553 TIM 2XF 67 Yrs.		5-26-1	933 Mar	yland
-	10a. Stete 10b. County 10c. City, Town or Local	ation			Od. Inside City Limi
ector	Pa Fulton Warfords	sburg			1 ☐ Yes 2 🛣
2	10e. Street and Number	10f. Zip Code	1:	Og. Citizan of What Cour	ntry?
at Director	219 Mallard Run Lane	17267		U.S.A.	
		l es Decedent ot Hispanic Origin Yes, specify Cuban, Mexican, P	? (Specify Yes or No-	14. Race - Americ	
y Fune	1 Never Married 2 Merried 1 ☐ Yes 2 ☐ No	Yes 2 No Specify:	uento rican, etc.)	Bleck, White,	
	3 Widowed 4 Divorced Yeer or Detes:	1 165 2 2 140 Specify.		Specify: WIII.	LLE
etec	15. Decedent's Education 16a. Decede (Specify only highest grade completed) (Give ki	nt's Usuel Occupation	workina	16b. Kind of Business/In	dustry
	Elementery/Secondary (0-12) College (1-4or 5+)	ind of work done during most of O NOT use retired)		Monumenta	llife
Ö		istrative As	sistant		
Be	17. Father's Name (First, Middle, Last)	18. Mother's	Name (First, Middle, M	Meiden Surname)	
2	Harry Dunn	Mar	garet	Krotee	
	19a. tntormant's Neme/Reletionship (Type, Print) 19b. Mailing	Addrass (Street end Number o	r Rural Routa Number	, City or Town, State, Zip	Coda) 172E
	John W. Divel Sr Spouse 219 M		- T		
5	1 Burial 2 Cremetion 3 Removel from State	etory or other piece)		20c. Location - City or To	MU
היא	4 □ Donation 5 □ Other (Specify) Crest La	wn Cemetery	111-16-21	000 Marri	ottsvii
any injury or other traumatic event, the Manage. To Be Comp		Name end Address of Fecility	. 13	censed Mo	ntician
58		arles S. Zar	IIIII		
	23a Part 1 Enter the disease or complete upone that caused the death. Do not enter	.O. Box 2394	diec or respiratory err	ore, Mu. Z	1203-59 Approximate
	23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter shock, or haert tailure? List on complications on each lina.	a a mode of dying, soon os can	Gloc of Tospiratory and	1	Intervel Between Onset end Death
ician dical	Immediate Cause (Final				1/
ner	Immediate Cause (Final disease or condition resulting in death) e.	12			TWELL
1	Due to (or es e consequ	ence ot):		1	
Examinet	b			1	
Exa	Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.	ence ot):		1	
		10000		1	
edical	resulting in death) Last	ence ot):			
. 2	d				
Physician	Doe to Company of an all the second s	tarbina sauca niver in Bart I	ngh Dide	bacco usa contribute 1	o the seven of da
1ys	Part tl. Other algorificant conditions contributing to death but not resulting in the unc	denying cause given in Pert I.		1-	bably 4 Unkr
	HUTE REUK FAILURA	Albert Co.	1 T	es 22 No 3 Pro	beloty 4 Onki
od by	(Gueble		24a. Was a		ere autopsy tinding
To Be Completed	cereinar offerty enge	ase	perform	med?	vailable prior to empletion of cause death?
du	als endil			1-	
ဝိ	JUNETE / PULLES		1 🗆 Ye		☐ Yes 2☐ No
Be	25. Was case referred to medical examiner?	Other:	Deeth (Check only or		
	1 Tes 3 No 1 I Inpatient 2 ER/Outpatient			enca 6 Other (Speci	fy)
ion	27. Menner of Death 1	28c. Injury at Work?		ow Injury occurred	
cat	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No		tenat and them to the Co	ral Bauta Mt t -
Certification:	4 Homicide determined 28e. Plece of Injury - At home, farm, street building, etc. (Specify)	et, rectory, office	28t. Location (Si City or Town	treet end Number or Rui n, Stata)	er Moute Number,
3					
edical	29a. Certifier (Check only Umedical Examiner: On the basis of examination and/or investigation)				
Med	one) and mennyr steted.				Oov Voor)
-	29b. Signeture end title of certifier	29c. License number	2 3	9d. Date signed (Month)	12 N
3511	Jus. Held 1	0265	23 1	-over-ev	14.0
10	30. Name and address of person who completed ceuse of daath (Itam 23a) (Type, P	rint)	TRUS R	et E, HX	JENTU
V	DISON DELAPORITY HO 1/110)	IEGKKL Y	7	D 2/742	
State	31. Date tiled (Month, Day, Year) 32. Registrer's Signeture	Sparkel	-	W	
	NOV 1 1 2000 Depart	July 1 Carlo			

NAME: DIVEL, HARRIET ETHEL 05/26/1933 67 / F

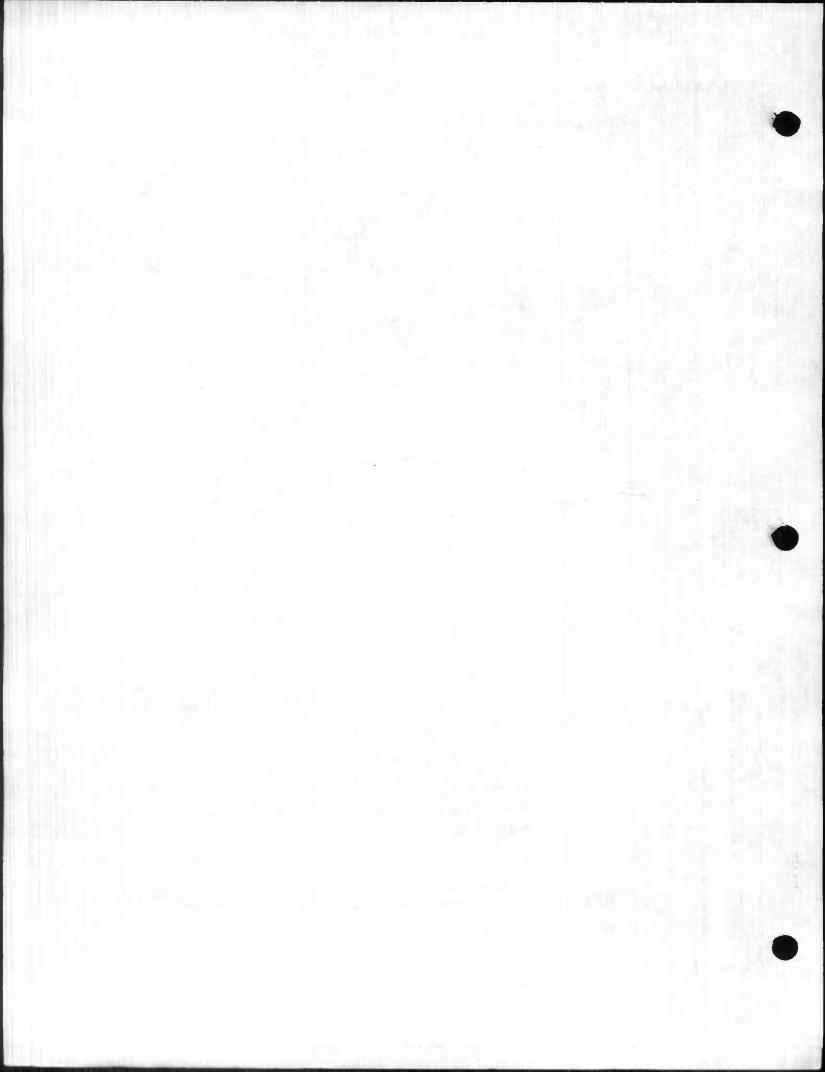




DOS: 10/27/2000 WASEEM, M. KHALID

State of Maryland / Department of Health and Mental Hygiene 0 0 36021

					Cer	tificate o	f Death		F	Reg. No.		001
		ma (First, Middle, La	st)			1997			2. Date of Dea	ath Day	Year	3. Time of Death
hysician	Roy A	dam Dash						-	Sev.	13	2000	0530
/Medical Examiner	4a Facility Name	(If not institution, giv					4b. City, To	own, or Loc	ation of Death	4c. County	of Death	
		ST AG	NES HO	ALtheor	2			LTIM	ore	BAG	Time	ire
uneral	5. Social Security	Number 6. S	Sex 7.	Age (In yrs. last 79	birthday)	If Under 1 Ye Months Day		Min.	8. Date of Birt (Month, De	h V Year)		lace (Stete or Fore
irector	216-12-	.5545	201	,,	Yrs.				Dec. 2	, 1920		MD
1	Usual Residence	10b. County		10c. City, To	own or Loc	ation					1	0d. Inside City Llmi
herre 23a or 23a-f show her must be notified at uneral Director	MD	Baltim	ore	Cato	nsvil							1 🗆 Yes 2 🖰 N
at be n at be n al Dire	10a. Street and N 429 Mar	yland Ave				10f. Zip Code 21228				U.S.A.		itry?
iner must iner must Funeral	11. Marital Status		12. Was Decede	200	13. V	Vas Decedent o Yes, specify C	f Hispanic Or	rigin? (Spec	cify Yas or No-	14. Rac	e - Americ	
ramine tramine by Fu		rried 2 Married 4 Divorced	1 XYas 2 If Yes, Give Year or Date	□ No 1942		☐ Yes 2☐XA			noun, oto.,	Specif	T Y1.	
A, the Medical is Completed	/So	15. Decedent's E		10	Sa. Deced	ent's Usuel Occ	cupation	st of workin	00	16b. Kind of B	usiness/Inc	dustry
Med aldr	Elementary/Se		College (1-4	or 5+)	life. D	OO NOT use ret	ired)	or working	'9	77. 7		
Con the	5				Pai	inter				Home 1		vement
Be Be	17. Father's Nam	e (First, Middla, Last)							Maiden Surnan	na)	
To To									ommerbo			
Taum Taum		Name/Relationship		1						er, City or Town		
F 25		d J. Dash	, son	20h Plans		Bucks	skin T	rail	Date	ad, MD		
unt: If he uny or of		2 Cremation 3 C 5 Other (Special		ate ceme	itery, crem	idge Met		1	1-17-00		ridge	
Imports any inju	21. Signature of	Funeral Service Lice	nsee			Name and Ad					1/10	21227
		r the disease, or comean failure. List only	hour					_	-	Arbutus	s, MD	Approximata
physician and a the bural-transit edical Examiner	Sequentially list if any, leading to cause. Enter Un Couse (Disease that initiated ever	conditions, immadiate derlying or injury nts	b. CHR 6	Due to (or as	a conseq	uenca of):	1106	AIR	WAY	0/36743	S E	
D. 3	resulting in death	L	d								1	
cia for	Deall Other de	-141		h h	- In the con-		-i in Deat		gab Did	tahaana sisa as	medicate t	a the serves of dea
tached tached	Part II. Other sign	nificant conditions					given in Part			Yes 2 No		o the cause of dea bably 4 🗆 Unkn
0 0		Congas	11VE /+	EARI	HH	LURE				100 20110	74.10	
should should leted									24e. Was perio	an autopsy emed?	av	ere autopsy finding allable prior to empletion of cause death?
page 2									10	Yes 250No		Yes 250No
	25. Was case ref	erred to medical					26 Plac	re of Death	(Check only o	,		2700 2900
8 6 0	axaminer?	130vo	Hospitel:	estient 2 PER	Outpatien	t 3□ DOA	Other:			dence 6 🗆 Otl	her (Snecil	(v)
2 - F	-	eath 5 Pending	28a. Date of (Month,		b. Tima of Injury	28c. l	njury at Vork?	2		how injury occu		,,
at Director: Attain ed in by the funera Certification:	2 Accident 3 Suicide 4 Homicide	6 Could not b	28e. Place of	Injury - At home , etc. (Specify)	, farm, stra				28f. Location (City or To	Street end Num wn, Stete)	ber or Run	al Route Number,
To the Funeral Dir completely filled in Medical Cert	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pleca, and due to the cause(s) end manner as stated one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to to and manner stated.											
completely lille Medical C		nd title of certifier 2	and manne			29c. Lie	ense number			29d. Date sign	ed (Month.	Dey, Year)
) 1	Ma		EDICAL		SNT			D		1		
1		dress of person who		of death (ttem 23	a) (Type, I	Print)	ENUE	RAL	TIMOP	11/13 RE MI	121	229
State	31. Date filed (Me			istrar's Signature			# 1					
State Registrar		100 5 A 20	00	episones.	1	DOOR	En)					



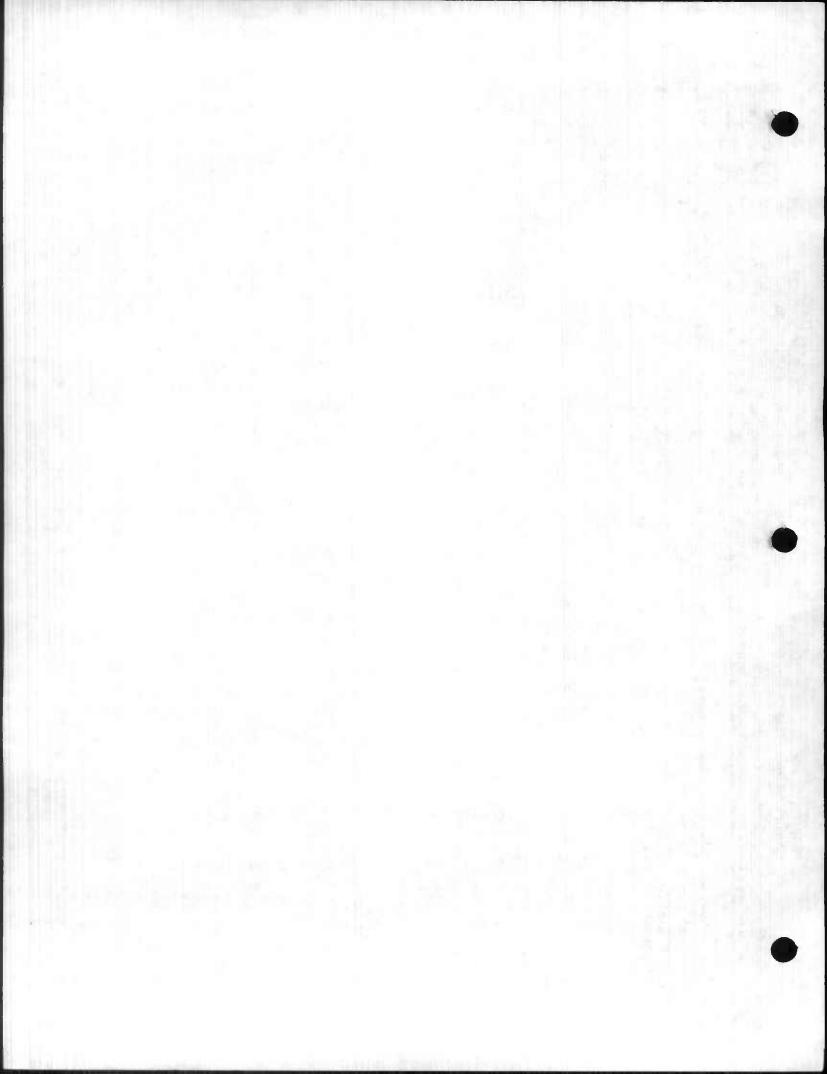
State of Maryland / Department of Health and Mental Hygiene

36022 Certificate of Death 3. Time of Death
2:20 PM 1. Decedent's Name (First, Middle, Last) 2 Date of Death November 10 **Physician** Mary G. Dodge /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not Institution, give street end number) Examiner North Arundel Hospital Anne Arundel Glen Burnie If Under 1 Yeer | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** 10 M 200 F Months 80 Yrs. 212 18 7480 Director Maryland Usual Residence of Decedent 10c. City, Town or Location r 28a-f show 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Anne Arundel Glen Burnie Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23s or the Medical Examiner must be r 7355 Furnace Branch Road 21060 U.S. Funeral 14. Rece - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Married s 1 and 2 should be filed within 72 hours aft if Health end Mental Hygiene. Item 27 Is marked other than "natural", or I Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: by White 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Eiementery/Secondery (0-12) College (1-4or 5+) 9th Worker Laundry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Archie MacMillan Margaret MacKenzie 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 sh Department of Health end Important: If Item 27 Is m any Injury or other traum pncs. Daughter Mary Stump 117 Warwickshire Lane Glen Burnie, Maryland 21061 20b. Piaca of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11/14/00 Baltimore, Maryland Moreland Memorial Park 4 Donation 5 Other (Specify) of Funeral Service Licenses 22. Neme and Address of Fecility Gonce Funeral Home P.A. 23. Pert1. Enter the disease of the plications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. In one cause on each line. Baltimore, Md. 21225 Approximate Interval Between Onset and Deeth **Physician** Myocardial Infarction 3 days /Medical Immediate Ceuse (Finel disaase or condition resulting in death) Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) dypertension 68760. Due to (or es e consequence of) Box Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.0. 23b. Did topacco use contribute to the cause of death? Covelor rescular Accident 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 2 P No 20 No 1 ☐ Yes 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medicai Certification: To 1 inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred After 5 Pending investigation The deeth.

Director: After in by the fur 1 Yes 2 No 2 Accident 281. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) To the T 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) E. Will To M.D. November 10, 2000 agree and address of person who completed cause of death (Item 23a) (Type, Rint) Haspital Drive, Glen Burnie 20061 Jeorge E. Wicks W. M.D., 301 Haspital Drive, Glen Burnie 20061 32. Registrer's Signature 31. Date filed (Month, Day, Year) State Registrar NOV 1 4 2000

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death NOVEMBER 10, 2000 SEYMOUR ETELSON M. 2:00 am 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days Months Hours 1XM 2□F 218-16-1967 79 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No BALTIMORE BALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21209 2109 WOODBOX LANE #B U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married WHITE 1 Yes 2 No Specify: Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) C.P.A. ACCOUNTING 18 Mother's Name (First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last) **ETELSON** POSNER DAVID LIBBY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) PEARL ETELSON / WIFE 2109 WOODBOX LANE #B - BALTIMORE, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Neme of cametery, crematory or other pleca) 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cremation 3 ☐ Removal from State BNAI ISRAEL CEMETERY 11/12/00 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Futural Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Fame the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, at heart failure. List only one ceuse on each line. Approximate Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part I

Physician /Medical Examiner

Physician

/Medical

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Funeral

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Hygiene. other than "neturn ent, the Medical E

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permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked other any Injury or other traumatic event.

filed within

Baltimore, Maryland 21215-0036

Examiner physician end s the burial-transit Physician/Medical 980 for signed by the a p Completed Be O this funeral Certification: death. Director: A

law requires that the death certificate be executed

or Attending Physicien:

Division of Vital Records, P.O. Box 68760,

	d	
Part II. Other significant cond	tions contributing to death but not resulting in the underlying cause given i	n

1 Yes 2 No 3 Probably 4 Unknown

24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Naturai 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 THomicide

(Check only one)

1/ Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and Affile of certifier

29c. License number 30379 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) WISTER MS 4000 064 11/99

Court Rd; Raltiner, MAZIZOS

Registrar

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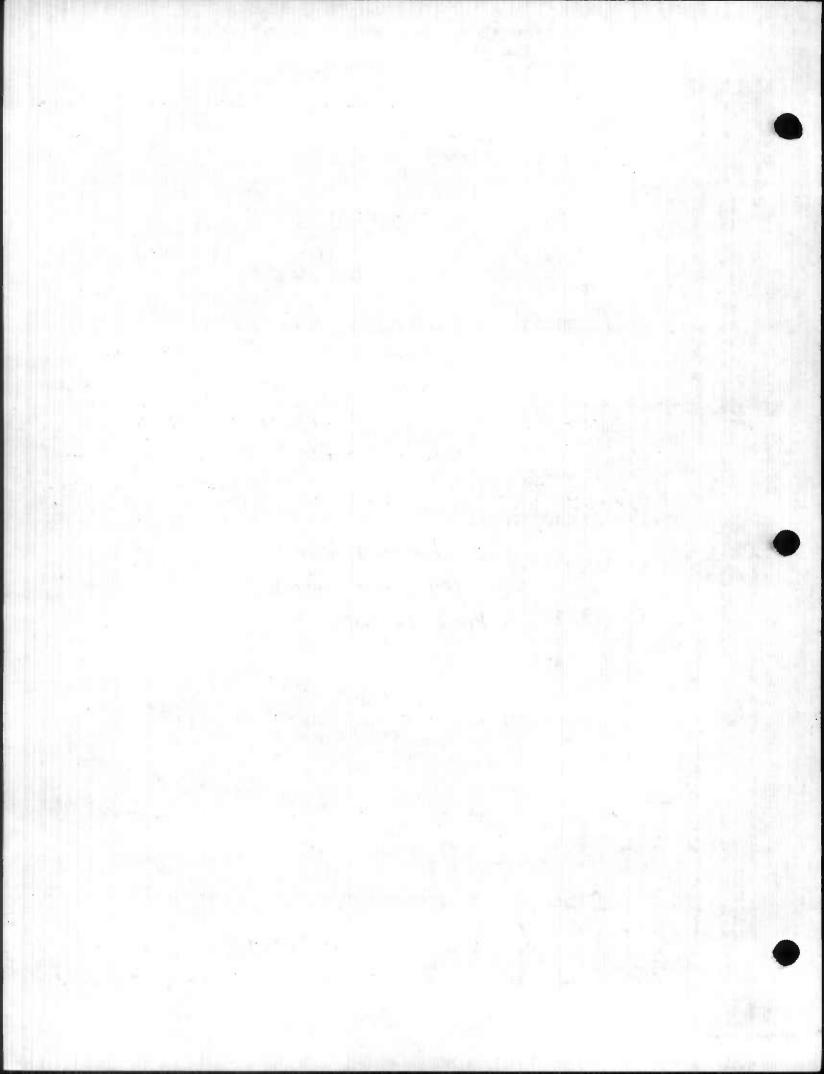
31. Date filed (Month, Day, Year) NOV 1 3 2000 32. Registrar's Signature

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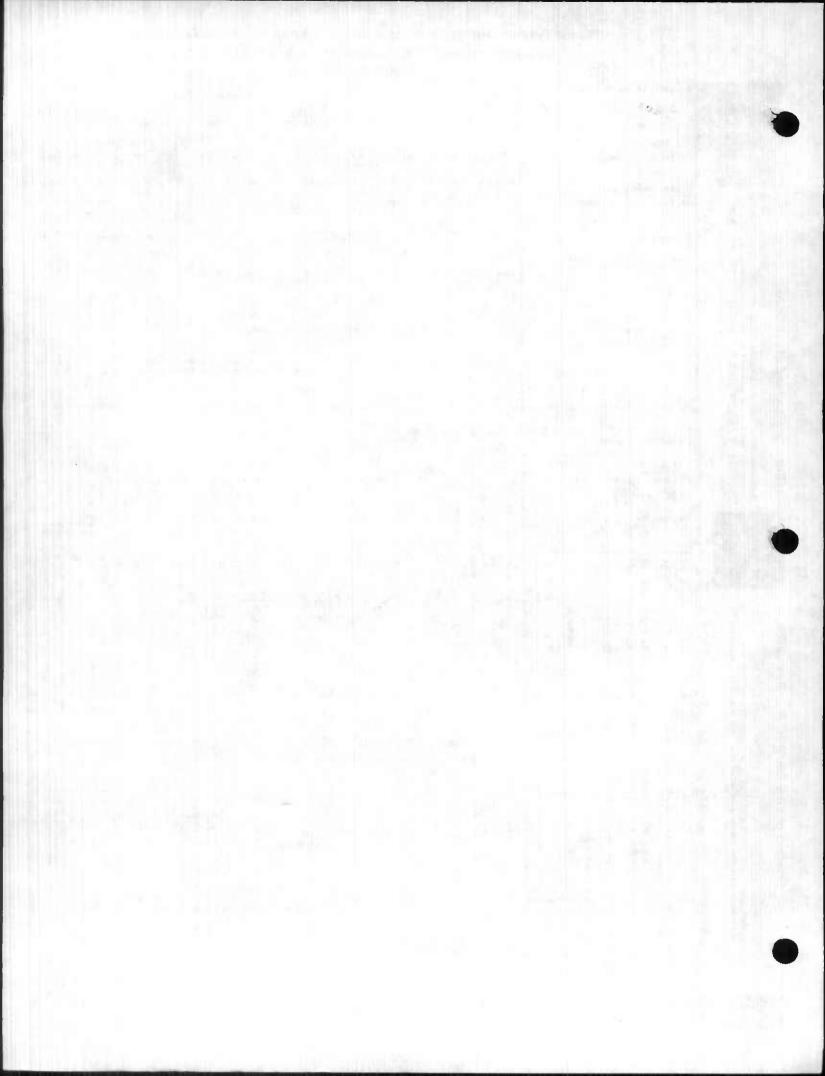
24 hours a Funeral D letaly filled Hospital

To the Hosp within 24 hos To the Fune completely fi



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 3 6 0 2 4

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Baltimore	permit. Page Department of Important: If any Injury or phos.	21. Signat	ture of Funeral Sarvio	a Licensee	and	10				ss of Facility Was				Hospital 20912	
6		23a. Part	1. Enter the disease, ik, or heart failura. Li	or complications the	et caused t	the death. Do	not enter	the mode of	f dyin	g, such as cardiac	or respiretory er	rest,		Approximate	
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State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 2. Date of Death 1. Decedent's Nama (First, Middla, Last) 3. Time of Death Month **Physician** November 9, 10:05 AM Bernard A. Franz 2000 /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore N/A 3919 Ridgecroft Road If Undar 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1 Ø M 2 ☐ F 7. Age (In yrs. last birthdey) Birthplaca (Stata or Foreign
Country) **Funeral** Months Yrs. Maryland 73 Nov. Director 219-22-0218 Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Directo Baltimore Maruland N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number mast be n 21206 U. S. A. 3919 Ridgecroft Road Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Wes Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puarto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 72 hours after 1 TYYas 2 □ No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married 8 Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: by Specify: 3 XWidowed 4 ☐ Divorced White Completed 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) Hygiens. Crown, Cork, & Seal Machine Repairman 12th Grade 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Meidan Sumema) es 1 and 2 should be fi of Health and Mental H I flem 27 is marked off ir other traumetic ever Francis Franz Alice Eastwood 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 5410 Hillburn Avenue, Baltimore, Maryland 21214 Sheila Kolego (Step-daughter) 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Pages 1 1 □ Burial 2 □ Cremetion 3 □ Removel from Stete important: any injury o Gardens of Faith 4 ☐ Donation 5 ☐ Other (Specify) 11/13/00 Baltimore, Maryland 22. Nama and Addrass of Facility
Schimunek Funeral Home Inc. 21. Signature of Funeral Service Licensee Mark 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Part1. Enter the disease, a complications that caused the death. Do not anter the mode of dying, such es cardiac or respiratory arrast, shock, or heart failure. List only one ceuse on each line. Approximata Intarval Batween Onset and Death Physician /Medical Immediata Causa (Final disaasa or condition rasulting in death) Examiner Dua to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed Sequantially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Dua to (or as a consequança of) Dua to (or as e consaguança of) use as the Box (P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the detached 1 Yes 2 No 3 Probably 4 Unknown 7 as been signed to 2 should be det Be Completed by of Vital Records. 24a. Was an autopsy performed? 24b. Were autopsy findings aveileble prior to comptation of cause of death? eged . 2 1 No 1 □ Yas 2 □ No 1 Yes Hospital or Attending Physician: 25. Was casa rafarred to medical 26. Place of Death (Check only gea) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 1 Yes 2 No Medical Certification: To After this 28a. Dete of Injury (Month, Day Year) funeral 27. Menner of Death 1 Naturat 28d. Dascribe how tnjury occurred 28c. tnjury at Work? Division 5 Pending Invastigation I Director: Aff 1 Yas 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be datarmined 3 ☐ Suicide 28a. Plece of Injury - At homa, farm, straat, fectory, office building, atc. (Specify) filled in by 4 Homicide To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigetion, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner stated. 29e. Certifier To the 29b. Signature, and title-el.pertities 29d. Data signed (Month, Day, Year) 29c. Licansa number 30. Nama and add who completed cause of deeth (Item 23a) (Type, Print) MICHAEL GOSTANT COUR 21334 BUSINESSE

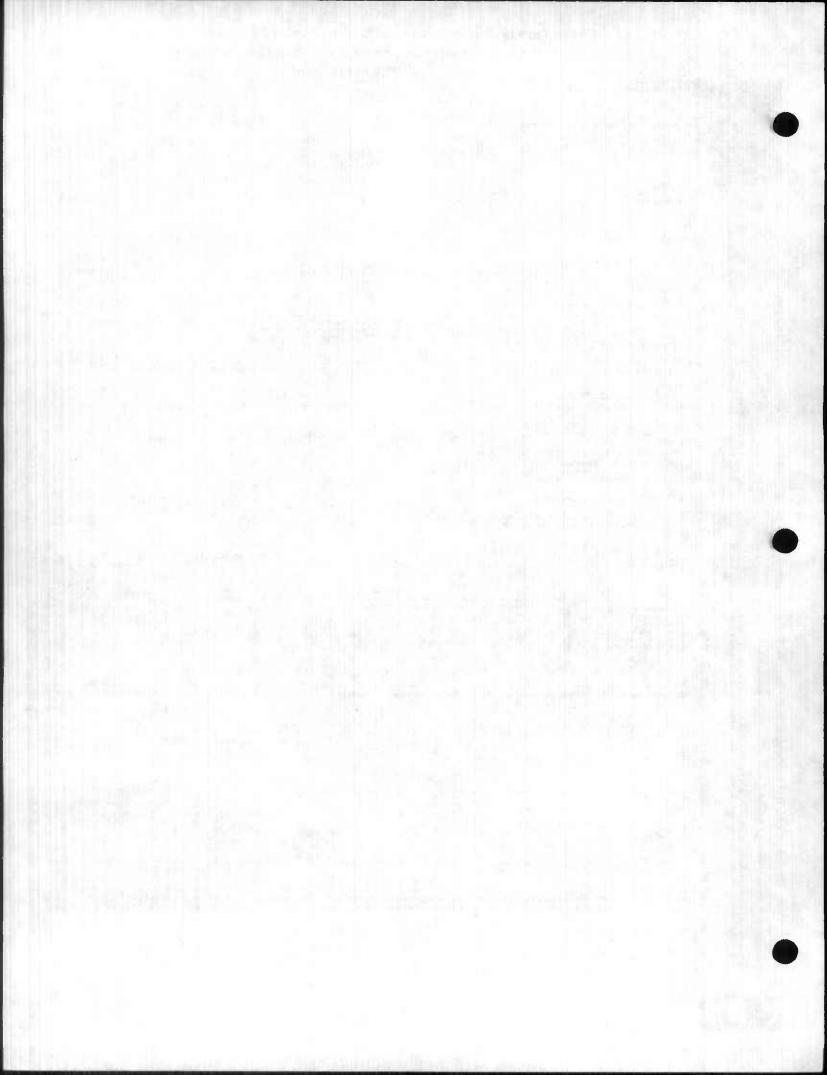
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DHMH 16 Rev 6/95

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32. Registrar's Signature

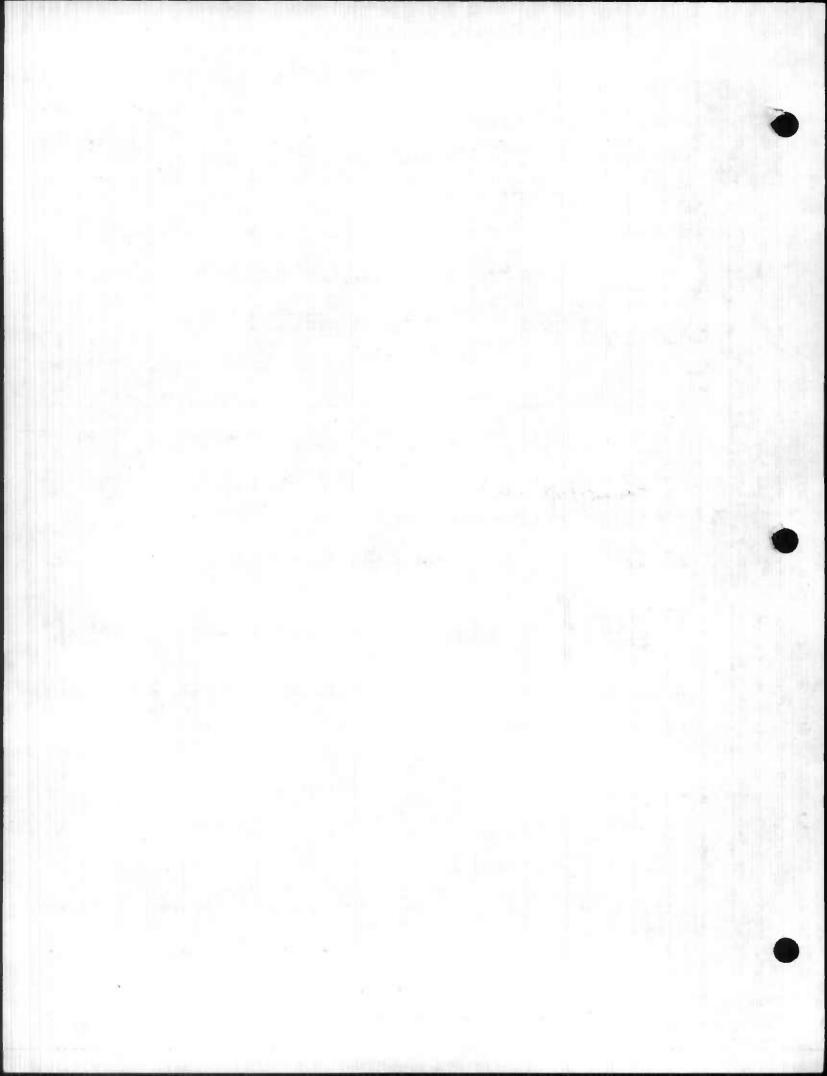


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician ,2000 Goldie Ann Friedman 2:25 am NOV /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Care Center Baltimore If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1□M 20F Deys Months 85 Director 18. 134-36-8363 Massachusetts 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Baltimore 286.0 Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 719 Maiden Choice Lane 21228 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: 'natural', or þ White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hied within 7 Hyglene. College (1-4or 5+) Elementary/Secondary (0-12) . Pages 1 and 2 ahourd be filled w fument of Health and Mental Hygler tant: If Ibam 27 is marked other th fury or other traumatic event, the Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Isenstein Rose Posner 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Elaine Farrant/Daughter 4613 Briarclift Road Baltimore, MD 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 Donation 5 Other (Specify) 11-13-00 Metro Crematory Inc. Baltimore, MD 22. Name end Address of Fecility
Cremation Society of MD, Inc. 21. Signature of Funeral Service Licensee gorchik Edward 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical End Stage Congestive Heart Failure Examiner Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): physician s the burial Physician/Medical Due to (or es a consequence of): resulting in de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2€ No Records, 5 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 Yes 2 No 1 Yes 2 No of Vital 25. Was case referred to medical axaminer? 8 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Affac Division 1 Natural 5 Pending 1 Yes 2 No death. investigation 2 Accident after death Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or yithin 24 hours at To the Funeral D completely Illed 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. edical 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November Mar Stores MA 15/05/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andres 227 7// 32. Registrar's Signeture Maiden choice lane Catarrile MD, 21726 5alazar 31. Date filed (Month, Day, Year) State NOV 1 4 2000 Registrar

DHMH 16 Rev 6/95

Verme

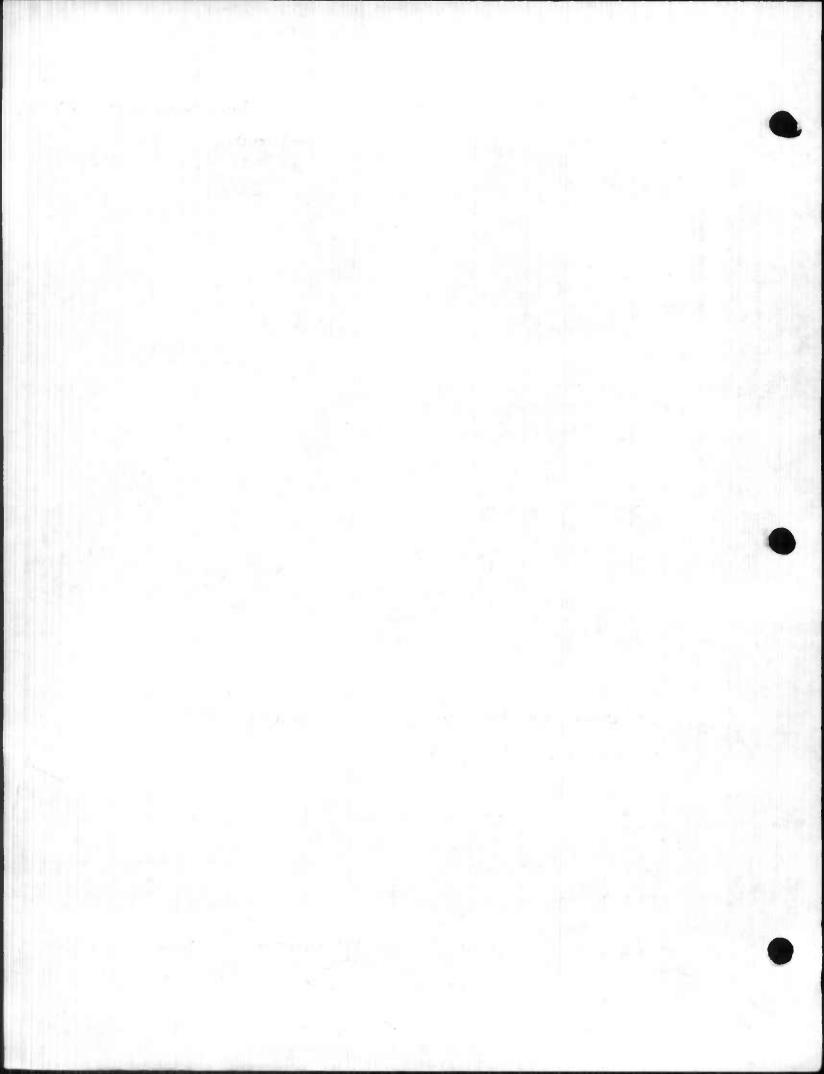


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O

ian	1. Decedent's Nama (First, Middle, L		7.00	Certificate of		2. Date of Death	g. No.	3. Time of Death
	JAMES	FrANKlix	1 Fox	ntz		Novemb	2000 900	1:52 PM
ical ner	la Facility Name (If not Institution, g				4b. City, Town, or Lo		4c. County of Deat	
	HARbox HUST	sital Cen	er		Baltin	1010	n/a	
	11.1.00	Sex 7. Age	(In yrs. last birth	day) If Under 1 Yaar Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		npiace (State or Foreign untry)
	214-14-4672	1 M 2 F	78 Y	rs.	Tiours iviii.	Sept. 20		ryland
-	Usual Residence of Decedent 10a. State 10b. County	422	10c. City, Town	or Location				10d. Inside City Limits
								1 ☐ Yes 2 ☑ No
Director	Md. Anne Ar	rundel Co.	Pasa	dena 10f. Zip Code		10	g. Citizen of What Co	
	219 Arundel Roa	ıd		101. 2tp C000	21122	10	USA	unity
Funeral	11. Marital Status	12. Was Decedant E Armed Forces?	ever in U,S.	13. Was Decedent of H	Hispanic Origin? (Spr	ecify Yas or No-	14. Race - Ame Bieck, White	
2	1 Never Married 2 Married 3 Widowed 4 Divorced		o WWII	1 □ Yas 2 No	Specify:	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		hite
De l	15. Decedent's (Specify only highest of		16a. [Decedent's Usual Occup Give kind of work done	pation	ina 1	6b. Kind of Business/	Industry
Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. DO NOT use retire	od)			
5	12	0	T	ruck Drive			Lyon Conk	Lin
0	17. Father's Name (First, Middle, La				18. Mother's Name			
2	James Edward Fo						h Minton	
	19a. Informant's Name/Reletionship James F. Fontz S	, ,, ,		Mailing Address (Street 9 Arundel I				(ip Code)
1	20a. Method of Disposition		20b. Place of I	Disposition (Nema of cremetory or other pla	ice)	Dete 2	Oc. Location - City or	Town, State
	1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			aven Memor:		11/13/200	00 Glen Bu	rnie, Md.
	21. Signature of Funaral Service Lic		1	22. Name and Addre	ass of Facility			
	11-	- 111.					Home P.A.	220
	23a. Part 1. Enter the disease, or co	mplications that caused	the death. Do no					Approximate
	shock, or heart tailure. List on	ly one ceuse on each lin	€.					Interval Between Onset and Death
	Immediate Cause (Final disease or condition	200	eumo	Ain			1	141 Dave
	resulting in death)		Due to (or as a co					7days
Examiner		5/2	laval		00			'7dmis
2	Sequentially list conditions.	Ь.	Due to (or as a co					
	if any, leading to immediate							
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2	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury thet initiated events resulting In death) Last	c	Due to (or as a co	ensequence of):				
	ceuse. Enter Underlying Cause (Disease or Injury thet initiated events resulting In death) Last		Due to (or as a co	ensequence of):				
	thet initiated events	c	Oue to (or as a co	ensequence of):				
	thet initiated events	d			iven in Part I.	23b. Dld tot	ecco use contribute	to the cause of death?
Physician/Medic	resulting In death) Last	dcontributing to death bu	it not resulting in	the underlying ceuse gi				to the cause of death?
by Physician/Medic	resulting In death) Last	dcontributing to death bu	it not resulting in	the underlying ceuse gi		e 1840	8 2 No 3 P	robebly 4 🗆 Unknown
by Physician/Medic	Part II. Other algnificant conditions	dcontributing to death bu	it not resulting in	the underlying ceuse gi			autopsy ed?	ware autopsy findings available prior to completion of cause
by Physician/Medic	resulting In death) Last	dcontributing to death bu	it not resulting in	the underlying ceuse gi		24a. Was an	autopsy ed?	robably 4 Unknown Ware autopsy findings
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DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Dey 4.50 P.M November 12 2000 PHYLLIS JUANITA FLAX 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Glen Burnie Anne Arunde If Under 24 Hrs. B. Date of Birth Hours Min. B. Date of Birth (Month, Day, Year) 9. Birthplace (State or Fore Country) Arunde If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 10 M 25 F JUNE 16, 1923 VIRGINIA 223-22-9907 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 XNo MARYLAND ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 127 NORTH MEADOW DRIVE 21060 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Merried 1 Yes 2 No Specify: Specify: WHITE 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) RECEPTIONIST DOCTOR'S OFFICE 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) CARTER GLADYS WOODRUM CHEATHAM 19a. Informant's Name/Relationship (Type, Print) (DAUGHTER) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MRS. PATRICIA LEE MILLER 127 NORTH MEADOW DRIVE, GLEN BURNIE, MD. 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 S Burial 2 ☐ Cremetion 3 ☐ Removel from State 11/15/2000 4 ☐ Donation 5 ☐ Other (Specify) GLEN HAVEN MEMORIAL PARK GLEN BURNIE, MD. 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 21. Signature of Funeral San 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 23a. Part. Enter the disease or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, show, or heart failure. Cast only one cause on each line. Onset end Death Immediate Cause (Finel disease or condition resulting in death) SEPSIS DRINARY TRACT INFECTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably A Unknown 24b. Wara autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medicat examiner? 26. Place of Daath (Check only ona) Hospital: 1 The patient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred

Physician /Medical Examiner

Examine

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Pages 1 and 2 should be nent of Health and Mental

Baitimore,

if hem 27 or other tr

Physician

/Medical

Examiner

Directo

88

Funeral

Director

28a-f

The law requires that the death certificate be executed Box 68760. Physician/Medical 987 P.0. Records, Completed of Vital 8 Certification: To Division

tal or Attending Physicien: The star death.

al Director: After this certificated in by the funeral director, pi

To the Hospital of within 24-hours of To the Funeral D completely filled in

State Registrar SATID

29b. Signature and title of certified

1. Natural

2 ☐ Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

5 Pending investigation

6 Could not be

29c. License number 51245

1 Yes 2 No

29d. Date signed (Month, Day, Year) November 12, 2000

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

DARIF 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHARIF NORTH ARUNDEL HOSPITAL-GLEW BURNIE-MIN

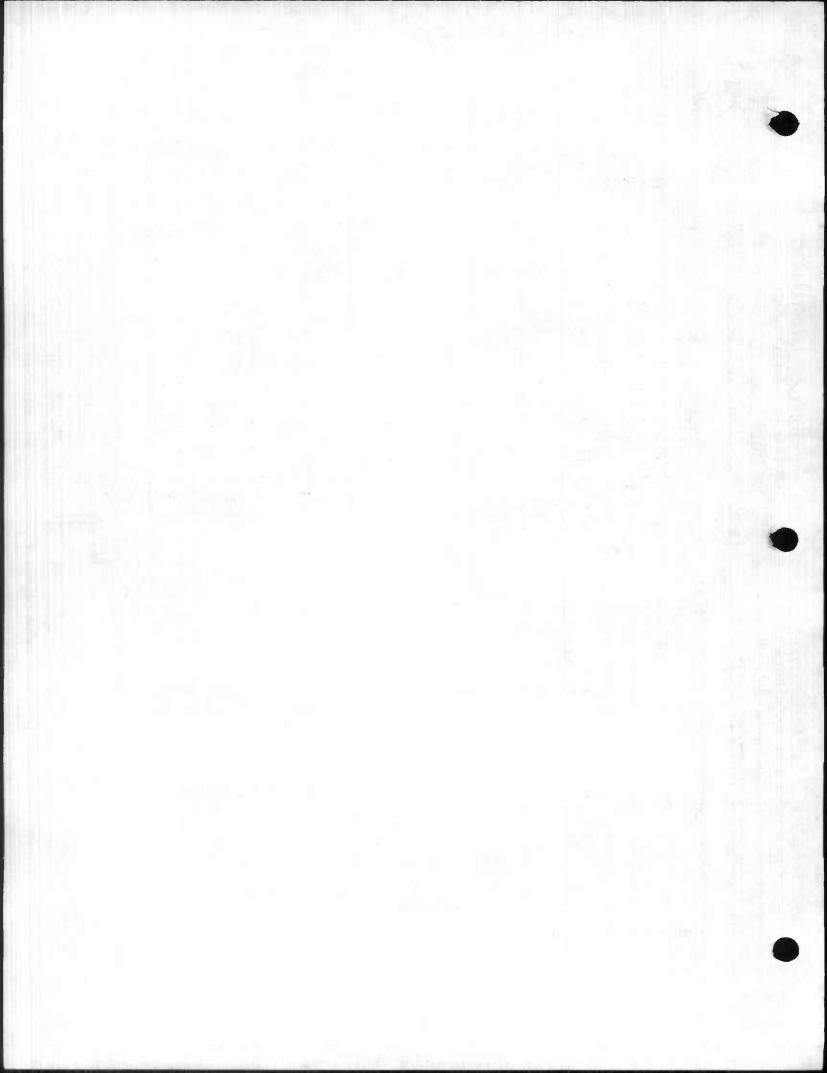
28c. tnjury at Work?

31. Date filed (Month, Day, Year) NUV 14 2000

32. Registrar's Signature

28h Time of

28e. Place of Injury - At homa, ferm, street, factory, office building, etc. (Specify)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name /First Middle I ast 2. Dete of Deeth 3. Time of Death **Physician** , 2000 Cartha Jo Freburger 10:17AM /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street end number) 4c. County of Deeth Examiner ARUN DEL GIEN BURNIE DACOUNT HOSPITAL NORTH If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Deys 1 M 20 F 220 48 9023 53 Director Maryland Usuel Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2€ No Anne Arundel Maryland Pasadena Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Hems 23s or 187 Inlet Drive 21122 U.S. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Noff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Stetus Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Married 2 Merried 8 1 ☐ Yes 2 No Specify. Specify: þ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Claims Adjuster 12 Social Security 4 years 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Montal Virginia Lily is marked Thomas Ingram 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Important: If item 27 is any injury or other tra once. Thomas Freburger / Husband P.O. Box 429 Pasadena, Maryland 21123 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1X Buriel 2 ☐ Cremetion 3 ☐ Removal from State Glen Haven Memorial Park 11/15/00 Glen Burnie, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 ramerouski ications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, one cause on each line. Approximete Intervat Between Onset and Deeth Immediate Cause (Finel disease or condition resulting in deeth) hours Due to (or as a consequence of) Physician/Medical Examiner Sequentially list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequence of) attending physician thet initieted events resulting in death) Last Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert f. 23b. Did tobacco use contributa to the ceuse of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical **Examiner**

The law requires that the death certificate be executed

À

Completed

Be

2

Certification:

Medical

Box 68760.

P.O.

Division of Vital Records.

After this certificate has

eral Diractor: After this certific filled in by the funeral director,

Attanding Physician:

death.

or A

To the Hospital o

PERUPAGE

Saltimore,

24a. Was en autopsy performed? 1 Yes 2 PNo

24b. Were autopsy findings available prior to completion of ceusa of deeth? 1 Yes 2 No

25. Wes cese referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yas 2 No 27. Menner of Death

28c. Injury et Work? 1 Yes 2 No

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one)

2 Accident

3 ☐ Suicide

4 ☐ Homicide

12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end menner steted.

29b. Signeture and title of certifier

29c. License number

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29d. Date signed (Month, Day, Year) 2000

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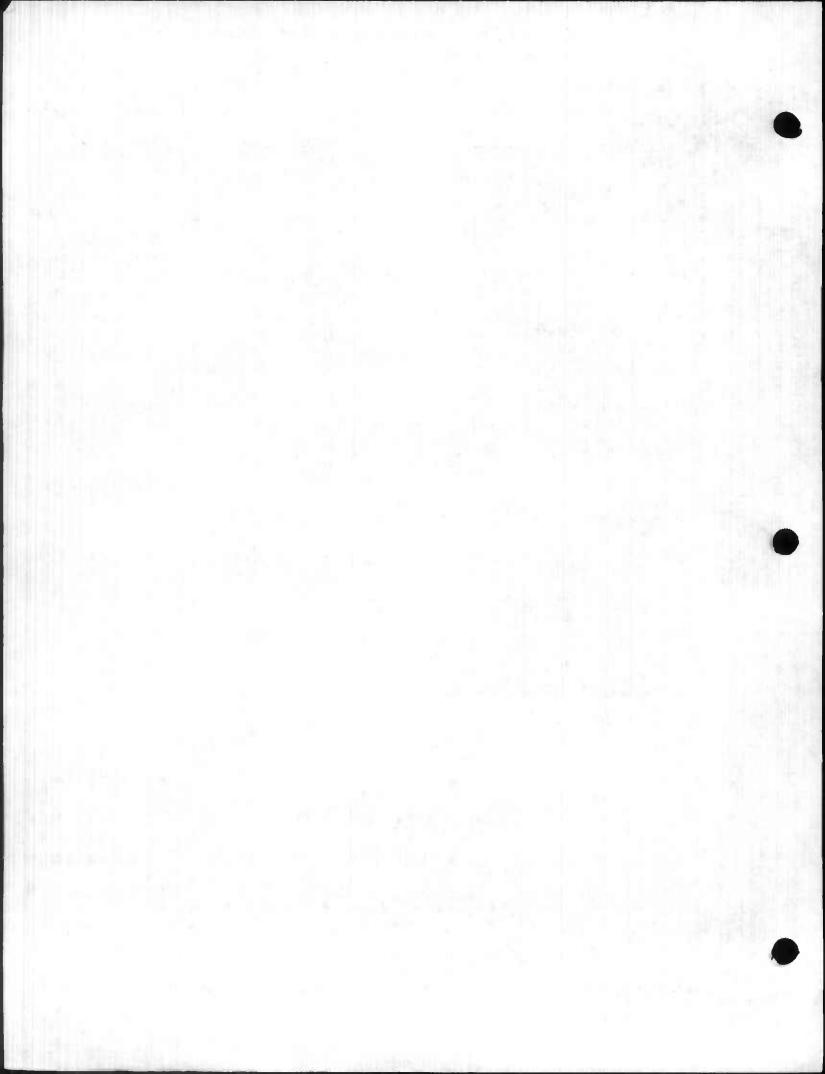
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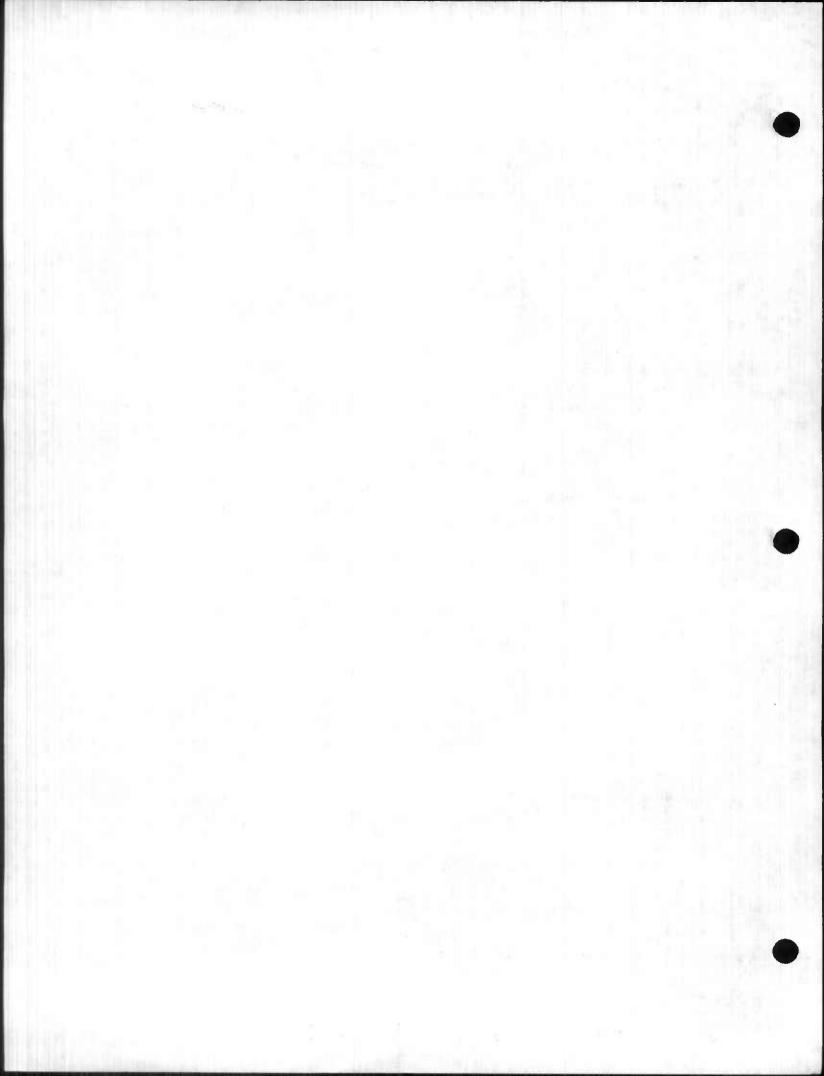
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State of Maryland / Department of Health and Mental Hygiene

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

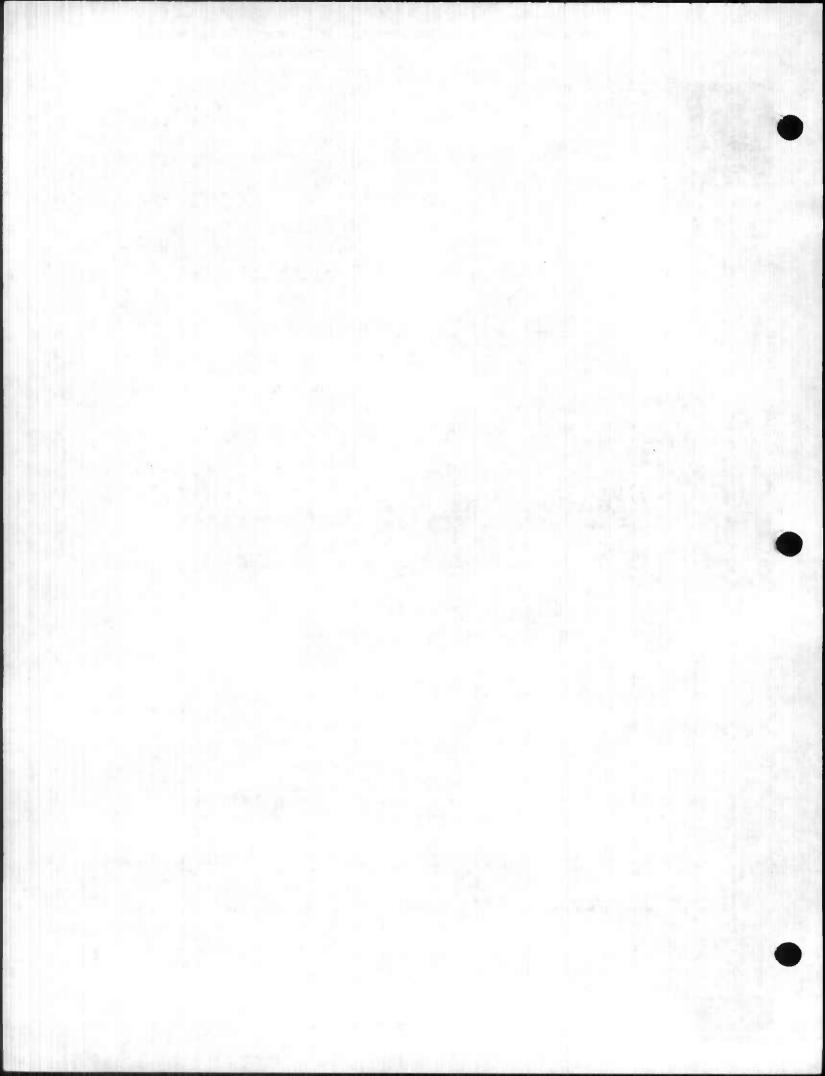
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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											s an autopsy formed?	av	fere autopsy find vailable prior to empletion of cau i death?
										10	Yes 2 No	1	☐ Yes 2☐ N
-	25. Wes case refe	rred to medica						26. Pled	e of Dee	th (Check only	one)		
	axaminer? 1 ☐ Yes 2 ☑	No	Hospitet: 1] Inpatien	t 2 🗆 E	ER/Outpatie	nt 3 DOA	hor		1	sidence 6 □Ott	her (Speci	ity)
_	27. Menner of Dea 1 Neturet 2 Accident		28a. Dei	te of Injury onth, Dey	/	28b. Time of Injury	of 28c. Inju				how injury occur		
1	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	ined 200. Pla	ce of Injui			reet, fectory, office				(Street and Numi own, Stete)	ber or Rur	ral Route Numbe
					Lens to acc	dadaa daal		ima data a	nd place	and due to the			
	29a. Certifier (Check only one)				examineti		h occurred et the t ivestigetion, in my						
	(Check only one)	2 Medical	Examiner: On the end me	basis of e	examineti		vestigetion, in my					and due t	to the cause(s)
	(Check only one)	2 Medical	Examiner: On the end me	basis of e	examineti		29c. Licen	opinion, de	eth occur		, date and place,	and due to	Day, Year)

Registrar **DHMH 16 Rev 6/95**

ORIGINAL



	Plea	se Type or	Prin	t In B	Black I	ndelible	lnk.	Assu	ire A	II Coples	Ar	e Legi	ble.		
		State	of Ma	rylan		partment				Mental Hy	gie	ne ()	0	36032	
					C	ertificate	of L	Jeath		1	Reg.	No.			
1. Decedent's Nem										2. Dete of De Month		Dey	Yeer	3. Time of Death	
	Ch	arles M	cIn	tosl	n Go	rdan				Novemb	-	10,	2000	11:35 PM	
4e Facility Neme (/			um <i>ber)</i>				4	b. City, To	wn, or L	ocation of Deat	h	4c. County	of Deeth		
Gilchri	ist Ce	nter						Tow					timo	ore	
5. Sociel Security N	lumber	6. Sex 1M M 2□ F			last birthda	y) If Under 1	Yeer_ Deys	If Under Hours	24 Hrs. Min.	8. Dete of Bir (Month, De	th sy, Ye	ar)	9. Birth	nplace (State or Foreign untry)	
225-12-40		IAN ZUF	8	5	Yrs.					AUG 24	١,	1915		ginia	
Usuel Residence of 10e. State	Decedent 10b. County			10a Cib	. Town or	Location				WY				10d. Inside City Limits	
					100										
Maryland	Balti	more		Ca	tonsv									1 ☐ Yes 2 ☐ No	
10e. Street and Nur	mber					10f. Zip C	ode				10g.	Citizen of	Whet Co	untry?	
719 Maide	en Choi	ce Lane	Apt	#62	2BR	21	1228	3				USA			
11. Meritel Stetua		12, Wes Dec		ver in U,	S. 13	3. Wes Deceder	nt of Hi	ispenic Ori	gin? (Sp	Bican etc.))-		ck, White	rican Indien,	
1 Never Merri	ied 2 Merr		2 N	0	- 1	1 ☐ Yea 25		Specify:		Thours, ottory				, 810.	
3 Widowed	4 Divorced	Year or I	Detes:			10 10a 2y	Ž 140	эрөспу.			Specify: White				
(Spec	15. Decedent	t'a Education st grade completed)		16a. Dec	cedent's Usuel (ve kind of work). DO NOT use	Occupe done d	etion during mos	t of work	cing	16b	. Kind of B	usin ess/ l	ndustry	
Elementary/Seco		College 4		+)		. <i>DO NOT</i> use .ness Ov					F	oundr	v Sa	les	
17. Father's Neme	(First, Middle,	Last)					1	18. Mothe	er's Nam	e (First, Middle	, Maic	den Suman	ne)		
John Doz	zier Go	rdan						Tuc	v Ia	tane Ba	1/1	or			
19e. Informent's Ne					19b. Me	iling Address (S	Street a				-		, Stete, Z	ip Code)	
Helen B.	Frick/	Daughter			486	Lakes (Our	-+ 1.7	estm	inster.	M	D 21	158		
20a. Method of Disp		Daugneer		20b. P	lece of Dis	position (Name	of		COLIII	Dete				Town, Stete	
1 Buriel 2 4 Donation	Cremetion	3 ☐Removel from	Stete			rematory or other		136	i i	1 12 00		Ral+	imor	e, MD	
21. Signature of Fu				110			4 .			1-13-00			THOL	e, ND	
Zelus	and 4.	regnela	ul		+ 1	22. Name end, Cremati	on	Soci	ety	of MD,	Ind	c.			
Edward	I A. Gy	egorchik				299 Fre	eder	ick !	Road	Balti	mo	re. M	D 2	1228	
23a. Pert1. Enter the shock, or hee	he diseese, or art feilure. List	complications that only one cause on	caused eech lin	the death e.	n. Do not e	enter the mode	of dylng	g, such es	cardiec	or respiretory e	errest,			Approximate Interval Between Onset and Death	
Immediate Cause ((Final		(0	190)	- 2	8							years	
resulting in deeth)				Oue to (o	ras a cons	sequence of):							1		
Commodiate that	nditions	b		Due to for	28 9 0000	sequence of/-							i		
Sequentially list confirmation in the sequentially list confirmation in the sequential list confirmation in the sequentially list confirmation in the sequential list co	nmediete	NO ST		Due to (or as e consequenca of):											
cause. Enter Unde Cause (Disease or that initiated events	injury	c	Due to (or es a consequence of):												
resulting in death) I					⊎s a CUIS	equence or):									

Physician /Medical **Examiner**

Te the Hospital or Attending Physician: The law requires that the death certificate be executed within 34 hours after death.

To the Fureral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated eventa resulting in death) Last

> 2 Accident 3 Suicide

4 Homicide

Physician /Medical

Examiner

Director

Funeral

To Be Completed by

Funeral

Director

"natural", or Nems 23a or 28a-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be flied within 72 hours after death a Department of Health and Merital Hygiers.
Important: if them 27 is marked other than "natural, or Nerns 23a any Injury or other trearmetic event, the Merical.

Pert II. Other algrifficant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown

24a. Wes an autopsy performed? 1 Yes

24b. Wera autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medicat axaminer? 26. Place of Death (Check only one) 1 Yes 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 27. Manner of Deeth 1 Neturei

28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Deacribe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

1 Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basta of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Cartifier 29d. Date aigned (Month, Dey, Year) 29c. License number 29b. Signetu

MO who completed cause of death (item 23e) (Type, Print)

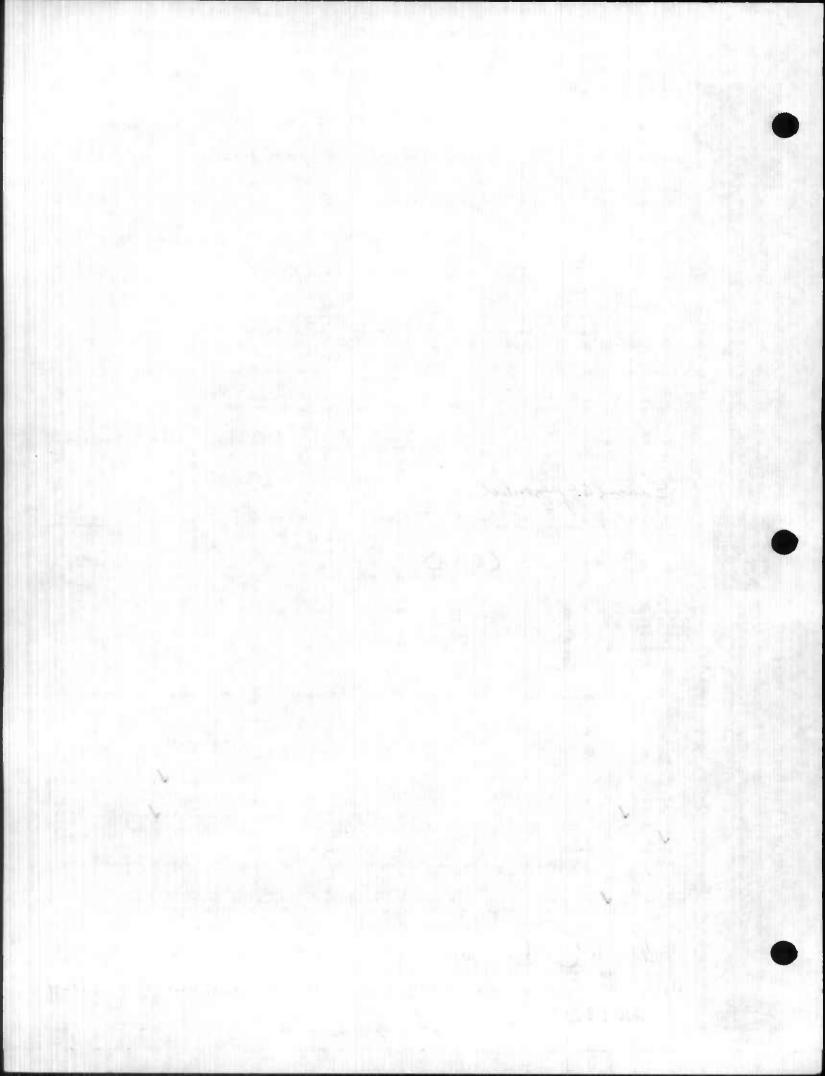
Charles St Balkmane MD 6601 Helen MD

00051926

State Registrar 31. Dete flied (Month,

32 Registrer's Signature

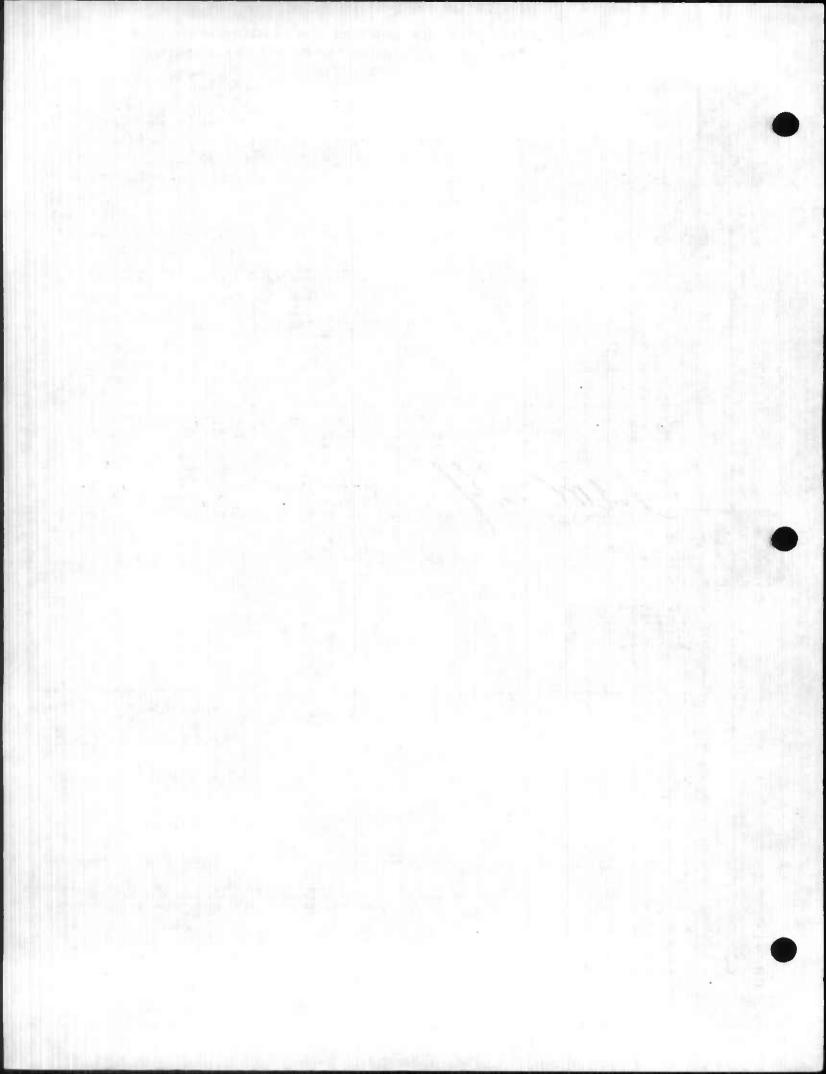
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State of Maryland / Department of Health and Mental Hygiene 0 0 3 6 0 3 3

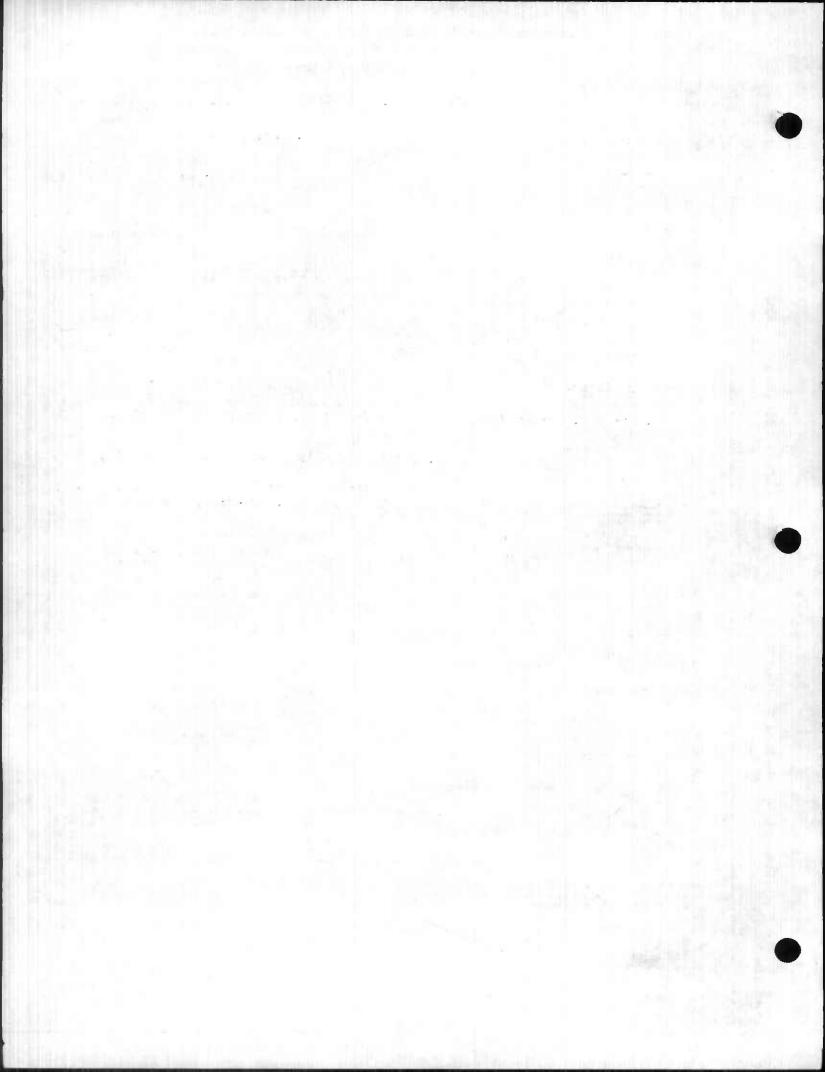
		Certificate of Death	Reg. No.	
Physician	Decedent's Name (First, Middle, Last) William Char	les Genhard+	Date of Death Month Day	3. Tima of Death
/Medical	En Provide Name (Mark in stitution with standard author)	4b. City, Town, or Logs		000 8:00 p.
Examiner	Franklin Spure Hospital	Center Rosedo	le Bal	+ more
Funeral Director	5. Social Security Number et Sex 7. Age (In) Irs. last birth 213-10-4724 to Stand 2 F 89	Months Dave Hours Min	Date of Birth (Month, Day, Year) April 10,1911	Birthplaca (State or Fore Country) Maryland
p .	Usuat Residence of Decedent 10a, State 10b, County 10c, City, Town	or Location		10d. toside City Lim
s after death with the Manyland , or flems 23s or 28s-f show caning must be notified at W. Funeral Director		Edgemere		1 □ Yes 2√2
with the Ma te or 28a-f a	10e. Street and Number 7239 Hughes Avenue	10f. Zip Code 21219	10g. Citizen of Wi United	
r flems 23a	11. Maritat Status 12. Was Decedent Ever In U,S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto Ri		- American Indian, , White, etc.
5 7 4 4	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:	Specify:	White
natural,	15. Decedent'a Education (Specify only highest grade completed) ((ecedent's Usuat Occupation Give kind of work done during most of working	16b. Kind of Bus	iness/Industry
	Elementary/Secondary (0-12) Cottege (1-4or 5+) PC	elice Sergeant		nforcement
			First, Middle, Maiden Surname Siebert)
s 1 and 2 should: Health and Men tem 27 Is marke other traumatic		Mailing Address (Street and Number or Rural and Number or Rural and Supplies Avenue Education Education 29 Hughes Avenue Education 20 Hughes Avenue Education 20 Hughes Avenue Education 21 Hughes Avenue Education 22 Hughes Avenue Education 23 Hughes Avenue Education 24 Hughes Avenue Education 25 Hughes Avenue Education 26 Hughes Avenue Education 27 Hughes Avenue Education 28 Hughes Avenue Ed	Route Number, City or Town, S gemere, Maryla	
of Health ar of Health ar I from 27 is r other trau	20a. Method of Disposition 20b. Place of E	Disposition (Name of crematory or other place)	Date 20c. Location - C	City or Town, State
Y C. T. T.		wn Cemetery 11/13/2	000 Baltim	ore, Maryla
permit. P Departme Importan any Injur DBCs.	21. Signature of Enferral Service Licenses	22. Name and Address of Facility Duda-Ruck Funeral 7922 Wise Ave. Du	Home of Dundal	
and it	23 Part 1. Enter the disease, or complications that caused the deeth. Do no shock, or heart failure. List only one cause on each line.			Approximate Interval Between
Physician /Medical	Immediate Cause (Finai	7		Onset and Deal
Examiner	disease or condition resulting in death) Due to (or as a co	Ingumunia		2 week
ed ist	De hydratio	^		Lweek
lificate be associted giphysicien and as the burlal-fransit	Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	nsequence of):		
hysicie the bu	Cause (Disease or trijury that Initiated events resulting in death) Last	nsequenca of):	1	
ding ding	d			
the atte	Part II. Other eignificant conditions contributing to death but not resulting in t	he underlying cause given in Part I.	23b. Did tobacco uss con	tribute to the cause of de
es that the death cer igned by the attendir be detached for use by Physician/A	Chronic Obstructive Julmo	nary Disease	1 Yes 2□ No	3 Probably 4 Uni
The law requires that the death ate has been signed by the atterpage 2 should be detached for Completed by Physicial	Peripheral Vascular Di	sobse	24a. Was an autopsy performed?	24b. Were autopsy findi svailable prior to comptetion of caus of death?
icien: The law certificate has rector, page 2 Be Comp	•		1 Yes No	1 Yes 2 No
riffical ctor, p	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)	7-
Physician: this certific ral director,	1 Yes 20 No Hospital: Unpatient 2 ER/Outp		e 5 Residence 8 Othe	
ding Ph. After After Inner	27. Manner of Death 1 Naturat 5 Pending (Month, Day Year) 2 Accident investigation 28a. Date of Injury (Month, Day Year)	3d. Describe how injury occurre	90	
or Attending after death. Director: After In by the lune ertification	3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm building, etc. (Specify)	Bf. Location (Street and Number City or Town, State)	or Or Rural Route Number,	
To the Hospital or Attending Physician: The law requires that the death cwithin 24 hours after death. **To the Funeral Director: After this certificate has been signed by the attendemplacely filled in by the funeral director, page 2 should be detached for unweller than the funeral director. **Medical Certification: To Be Completed by Physician	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, (Check only one) Medical Examiner: On the basis of examination and/one)			
Within To the	29b. Signature and title of certifier	29c. License number	29d. Date signed	(Month, Day, Year)
JAN	Millian - Waren ND WARREN	D0055331	11/9/0	
000	30. Name and address of person who completed cause of death (ttem 23a) (T	EVI	rive Talli	Marylanda
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	to the total of the state of	THE JOITIMON	L March
State Registrar	NOV 14 2000 > Bereva	D sports		

DHMH 16 Rev 6/95



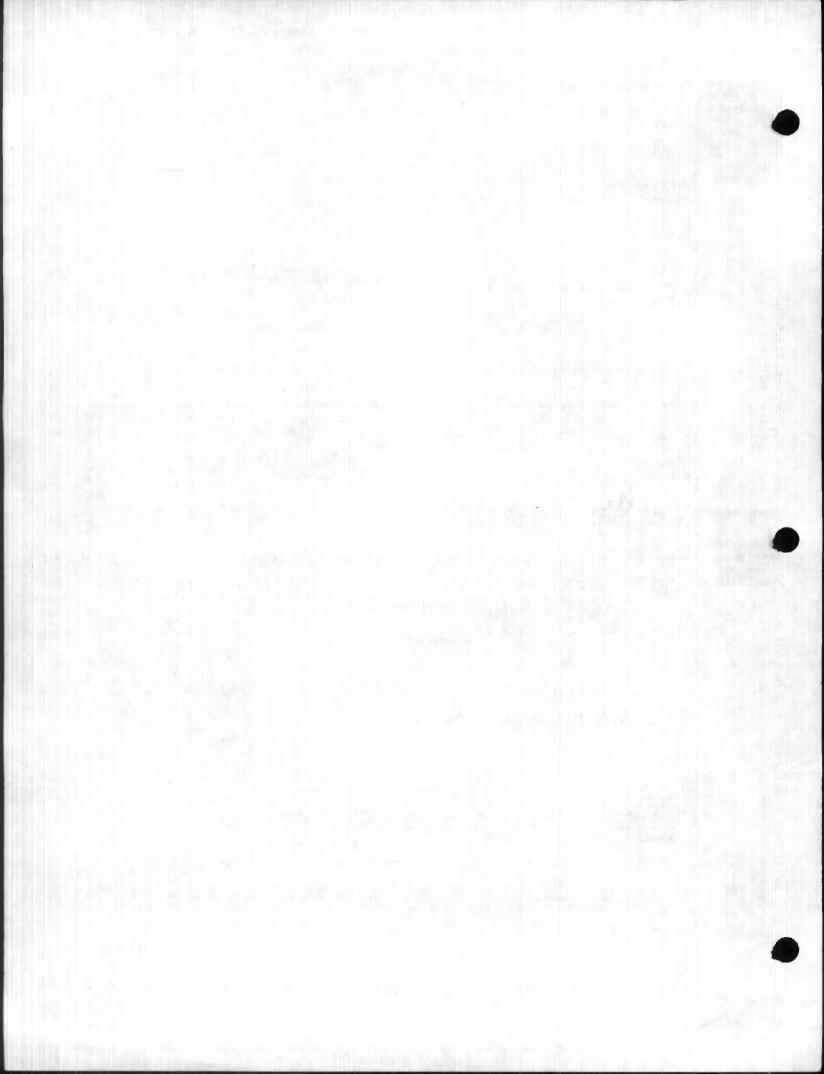
	1. Decedent's Na	me (First, Mide	dle, Last)								of Death			3. Time of Dea	
ysician		ne A		Gre	sdo	Mor		Dey er 9,	Year 2000	7:40 P					
/Medical Examiner	4a Facility Name	(If not institution	ion, give str	eet end nu	um <i>ber</i>)				4b. City, Town, or			4c. County		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	A STATE OF	ntree C	11.5						Essex			Ba	1timo	ore	
	5. Social Security		6. Sex		7. Age (In y	rs. last birthday) If Unc	der 1 Year		s. 8. Dete	of Birth				
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	10a. State	10b. Count	ty	10c. City, Town or Location 10d. Inside City Lin ESSEX 1 □ Yes 20											
Directo	Maryland		Bal	timor	e				Essex	Κ.					
	10e. Street and N	intree	Court	101. Zip Code 21221								What Cour State	,		
Funeral C	11. Marital Stetus				cedent Ever in	U,S. 13.	Wes Dec	cedent of h	Hispanic Origin? (S an, Mexicen, Puer	Specify Yes	s or No-		ce - Americ	can Indian,	
by		rried 2 Me			2 X No				Specify:			Specify		White	
Completed	(Sp.	15. Decede	ent's Educa	tion completed)	16a. Dece	edent's Us	sual Occup work done	pation during most of we	orkina		6b. Kind of B			
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00	12 Year					Com	pute	r Ope	erator					cion	
Be	17. Father's Name								18. Mother's Na				ne)		
2		Lindner								phine			0	0.4.	
	19e. Informant's	Neme/Relation			on)				tend Number or A errace I					21234	
	20e. Method of Di		DOLZ	ey (D		o. Pleca of Disp				Date		0c. Location		own Stete	
	1 🖾 Buriel	2 Cremetion		movel from	Chala	cemetery, cre	matory o	r other pla	emetery						
		5 Other (S					11/13	/2000	Dune	la IK,	maryrar	
SUCE	21. Signeture of unerel Service Licensee 22. Neme end Address of Facility											Dundal	k, I	nc.	
15 8 4	Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222														
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DHMH 16 Rav 6/95



Amended Item#8	perFHG789				d / Depa		t of H	lealth ar	nd Mental H		ne ()		360	35
	1. Decedent's Name (First, Middle, Last)									2. Deta of Death			3. Time of	Death
Physician	Thelma	M. Heinze	erling						Nov.	Nov. 8, 2000			6:55	AM
/Medical Examiner		(If not institution, give		7)				4b. City, Town		Location of Death 4c. County of Death				
Funeral	Genes	is Elder (lare					Raltin	nore High	e Highlands Anne Arund				
	5. Social Security	Number 6. Se	7. A		ast birthday)	If Under Months	1 Year Days	If Under 24	Hrs. 8. Dete of	Birth Day Yea	1915			
Director	220-36-7	210	□M 2\(\overline{\text{F}}\) F	85	Yrs.	MOTITIES	Days	110015	Feb.	8. Dete of Birth (Month, Day, Year) 1915 Feb. 7, 2000 MD				
death with the Maryland ma 23e or 28e-f show Erwat be notified at neral Director	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location											140	d Incide Ci	in I in to
	MD	N/A	Baltimore										ld. Inside Ci	
he M		Darci	-				40.		24					
Dir.	10e. Street and Number 10f. Zip Code 2 168 Poulton St.										S.A.	rnat Count	ryr	
auth a 23								n? (Specify Yes or			a - America	n Indien		
after or its	**	rried 2 Married	12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:			ify Cub	Specify:	Puerto Rican, etc.)	tc.) Bleck, White					
15-002 72 hours natural,		15. Decedent's Ed	ucation		16a. Decedent's Usual Oc			pation		16b. Kind of Business/			ustry	
1 21215-0 ed within 72 ho ygiene. or than 'netur it, tre Wedgell.	(Spe	cify only highest grad		life. DO NOT use			rk done se retire	during most o d)	of working					
d withir giene.	1	0	College (1-4or 5+)			emake	r	100		Ow	n hom	e		
De ile	17. Father's Name	e (First, Middle, Last)				1		18. Mother's	s Name (First, Mid	die, Meid	en Sumem	e)		
aryland 2 should be filed v ind Mental Hygie or marked other t umatic event, it To Be Co	Walter	Hoffman						Ann	ie Brooke					
M Page		Name/Relationship (7 t Heinzer:				Poul			or Rural Route Nu Baltimore				Code)	
Baltimore, Notes and Semit. Pages 1 and Semiter of Health Important: If them 27 in the Internation of Internation of Internation of Internation	20a, Method of Di			0.6	ace of Dispo	osition (Nam	ne of	cel	Dete	20c.	Location -	City or To	vn, State	
TO age and o		2 ☐ Cremetion 3 ☐ 5 ☐ Other (Specify		θ		•			ark 11-11	-00	E1	kride	ge, MD	
Baltimo		uneral Service Dicem							1				, , , , , , ,	
Ball permit Departiment eny Ir	D \1	Da D	dunk	do						ne of Lansdowne				
	23a Part Enter	the disease, or comp	lications that caus	ad the death						Rd. Arbutus, MD. 21227				'e
Discoulation of the same of th	shock, or he	eart failure. List only	one cause on each	line.	. 00 1101 0111		00.09.	19, 000, 00		,			Interval Bet Onset and	ween
Physician // // // // // // // // // // // // //	Immediate Cause	(Finel	C 1	61.		-		1.						
Examiner	disease or condition	ion	a. End				WE	Nte	4				1 yer	35
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760, be executed sictan and burist-transit	Sequentially list of if any, leading to	immediate	Due to (or as a consequence of):								1			
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certificate vision physics as the	resulting in death) Last	Due to (or as e consequence of):											
Box 6 Box feetification of the second of th			d									1		
S, P.O. Box 687 se that the death certificate gned by the attending phys be detached for use as the by Physician/Medic	Part II Other sign	ificant conditions or	contributing to death but not resulting in the underlying cause given in Part I. Scul of Accident					23b. (23b. Did tobacco uas contributs to the causs of death?					
trine do trine do trached tached									1 Yes 2 No 3 Probably 4			Unknown		
S, P es that gred be deta be deta	Cere	60105							7					
									of death?			re sutopsy	findings	
								_ P				npletion of	cause	
I Rec The law sate has t page 2 s	DE LA													No
	25. Was case refe	arred to medical						OC Diagon			20,10		1103 2	1140
	examiner?	-	26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Provided Hospital: 1 Residence 6 Other (Specify)								d			
Physic rithis control direction of Ton	27. Manner of Dea		1 Inpatient 2 I EH/Outpatient 3LI DOA 4/2/Nul					28d. Describe how injury occurred						
ding ding	1 Natural 2 Accident	5 Pending investigation	(Month, Day Year) Injury					rk? Yes 2∐No	0					
Division of an arter death. at Director: After ted in by the funer. Certification:	3 Suicide	6 ☐ Could not be	NO CON Change of the control of the						28f. Locatio	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Div Jord	4 Homicide	determined							City or					
Division of the Hospital or Attending Physipin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one)	Certifying Phy	relcian: To the bes	of examinat	vledge, deat ion and/or in	h occurred a	at the ti	me, dete and opinion, death	place, and due to occurred at the til	the cause ne, date	e(s) and ma and place,	nner as st and due to	ated. the cause(s)
Z omple	29b. Signature en	dive of certifier				290	. Licen:	se number		29d.	Date signe	d (Month,	Day, Year)	
F3F8				-	DS346									
b	00.11	Ille	W	W/O				22760			11/01/00			
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0111	Jude V	onth. Day. Year)		845 strar's Signet	ture	DM00	09	KOBC	d Glev	1 0	21 11	- 1 1v	-0 0	0 1
State Registrar	NOV		0	ander	B	Lom s	5/							

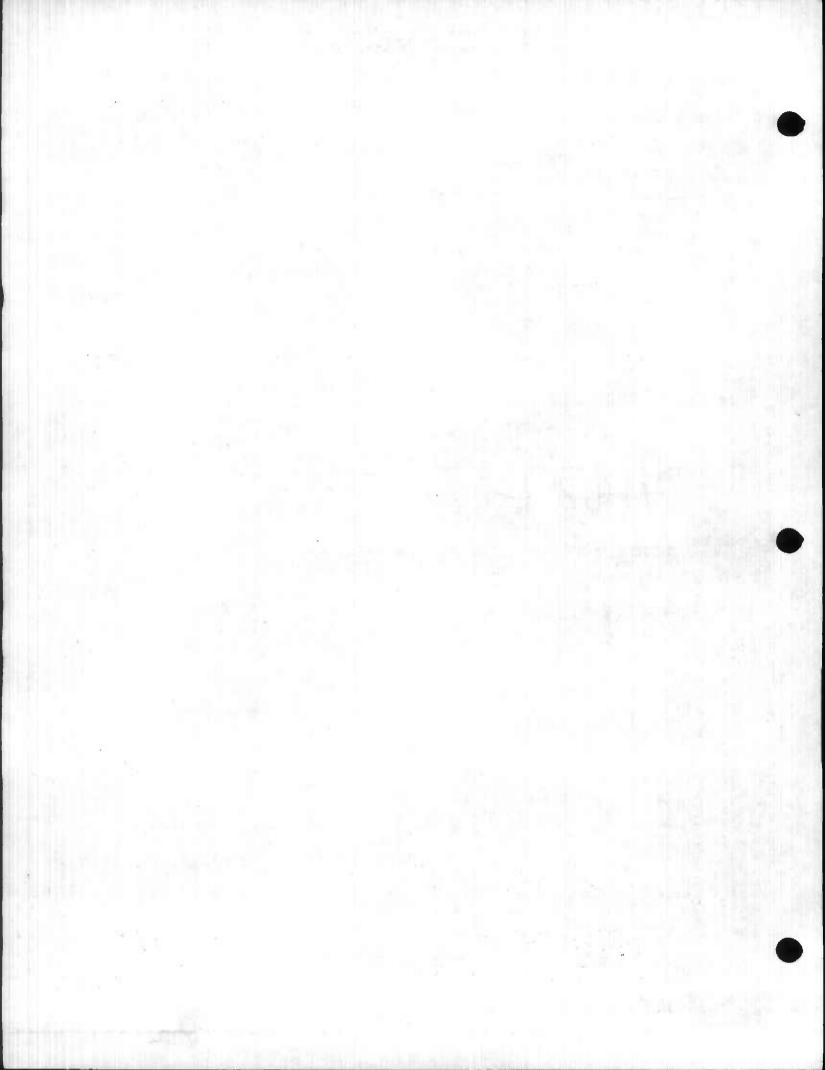
DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene 0.0 3.6 0.3 6

		Certificate of Death Reg. No.											
		1. Decedent's Name (First, Middle, La						. Date of Death	Deu	Year	3. Time of Deal	ith	
	nysician	LENA	М.	HAI	HALL			Month Day NOVEMBER 1			11:10 2	AM	
	Medical kaminer	4a Facility Name (If not institution, giv					4b. City, To		tion of Death	4c. County			-1
Funeral Director		185 VIRGINIA LAN 5. Social Security Number 6. S 212–54–9389		x 7. Age (In yrs. last birtho			GLEN BUI // If Under 1 Year If Under 24 Hrs Months Days Hours Min			ANNE ARUNDEI te of Birth onth, Day, Year) Y 19, 1925 Sentunder 9. Birthplace (S Country) KENTUCK			reign
Manyland	Maryland 4 show fied at	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MARYLAND ANNE ARUNDEL GLEN BURNIE							10d. Înside				
th with the 23s or 28s	ust be notified al Director	10e. Street and Number 185 VIRGINIA LAN		10f. Zip Code T B 21061					10g. Citizen of What (try?	
her dea	Examinar in by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No If Yes, Give			dispanic Ori an, Mexicar Specify:		fy Yes or No- can, etc.)		e - Americ k, White,		
2 72 70 O	ted ted	15. Decedent's Ed		16a.	Decedent's Us	ual Occup	pation	A = 4 = state =	16	b. Kind of Bu	usiness/inc	dustry	
Maryland 21215-0036 d 2 should be tilled within 72 hours at th and Mental Hygiens. 7 is marked other than "natural", or	r. the Medical Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)		ide. DO NOT	ive kind of work done during most of wor b. DO NOT use retired) IMFMAKER			rking		OWN HOME		
D BE	Be	17. Father's Name (First, Middle, Last,					18. Mothe	er's Neme (/	First, Middle, Ma	iden Suman	10)		
Tal day	90	MANTFORD		HANNAH	I		CZ	THERI	NE		HOLBI	ROOK	
J of D	-	19a. Intormant's Name/Relationship (Type, Print)	19b.	Mailing Addres	s (Street			Route Number, (City or Town,			
- 590	Cher tras	DIANE LANHAM (1	DAUGHTER)	20h Place of	Disposition /Na	ame of			ENA, MD	. 2112 c. Location -		wn State	
Saltimore semil. Pages 1.1 Separtment of He mportant: If Item	ury or o	1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		cemetery	AND VET	other pla		1	1/06/200	CROWNS			ij
Depart Depart	any in	21. Signature of Funeral Service Operation 22. Name end Address of Facility SINGLETON FUNERAL II 1 SECOND AVENUE, S.W., GLEN BURNIII											1
/Med	Physician /Medical Examiner	23a. Pait 1. Enter the disease or com shock, or heart tailura. List only Immediate Cause (Final disease or condition resulting in death)	· Luc	160	Auconsequence of	EK	ng, such as	cerdiac or r	respiratory erres	t,		Approximate Interval Between Onset and Death	h -
Centif	use as the buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	bue to (or es e consequence ot): d								9201		
death ce	I for usa										ribute to the cause of death?		
that the ded by the	Physi	Part II. Other significant conditions of	ons contributing to death but not resulting in the underlying ceuse given in Part I.										
requi	2 should		47						24a. Was an performe		ev co	ere autopsy tindir ailable prior to mpletion ot ceuse death?	
The law	Com								1 Yes	30 NO	1[Yes 20 No	
	Be C	25. Was cese reterred to medical 26. Place of Death (Check or											
Or VITA Physician:		examiner? 1 Yes 2 No	Hospital:	2 □ FR/Out	patient 3 0	OA Ot	hor		ing Home 5 Assidence 6 □Other (Specify)				
	7	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day)	28b. T		of 28c. Injury at Work?		28	28d. Describe how injury occurred				
5 8 8 8	led in by the funera Certification:	3 Suicide 6 Could not be determined						28	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
the Hoepital filn 24 hours the Funeral	Completely filled in by Medical Certifi		ysician: To the best of r niner: On the basis of ex										
of the	W Count	29b. Signature and Itie of certifier	-1/0 6	-	2	9c. Licen	icense number 29			29d. Date signed (Month, Day, Year)			
	1	> C/1/pot	Shat	MA		1	2000	94		11/12/00			
P	b	30. Name and address of person who	completed cause of day	th (item 23a) (Type, Print)	wo	od A	ed.	Glent	Brair	14d	2106/	,
-	State egistrar	31. Date filed (Month, Day, Year)	Sewel 32. Registrar's	s Signature	las d	,	(- 111	· cuj		



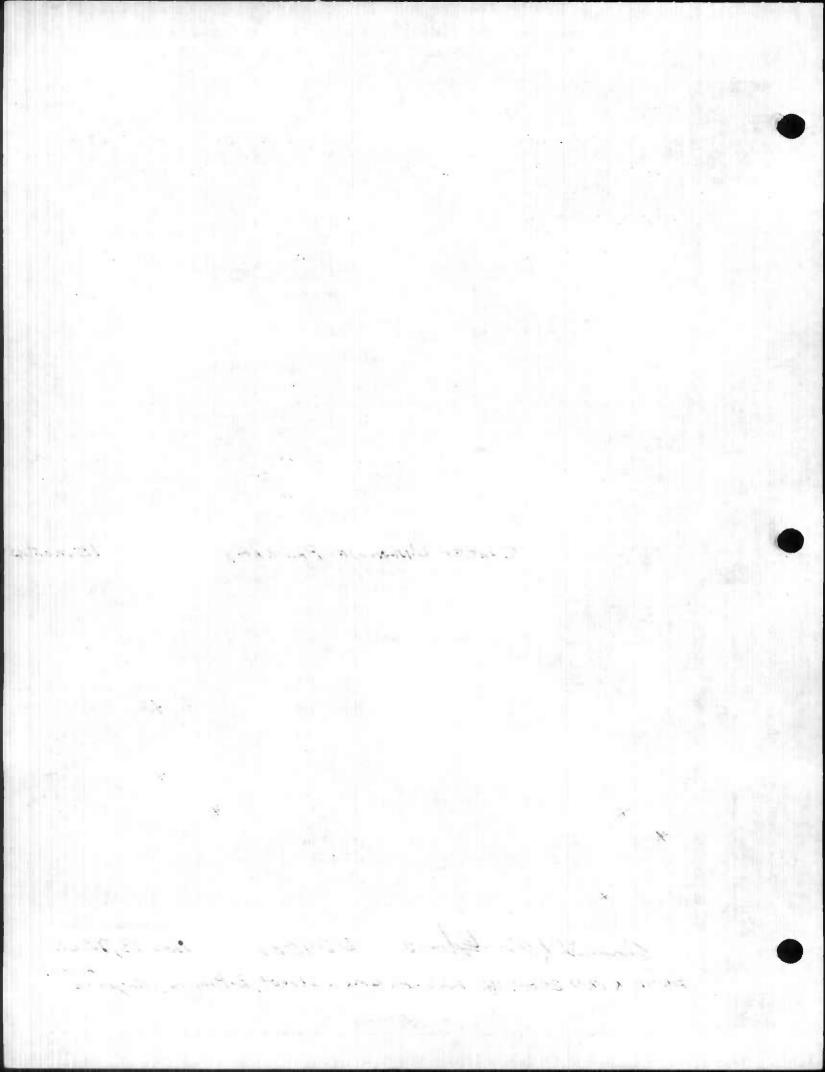
State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month Vaar **Physician** JOSEPH BECKETT HALEY 10:19 PM NOVEMBER 11, 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 201 2ND AVENUE, S.W. ANNE ARUNDEL GLEN BURNIE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Deys 10XM 2□ F 217-72-6011 36 JULY 28, 1964 Director Usual Rasidence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or harra 23a or 28a-t show edical Examiner must be notified at 1 Yes 2 No Director MARYLAND ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 2ND AVENUE, S.W. U.S.A. 21061 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yes, Give Year or Datas: 14. Raca - American Indian, 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Elementary/Secondary (0-12) College (1-4or 5+) RAMP AGENT AIRLINES 18. Mother's Name (First, Middle, Maiden Surname) 17. Fathar's Nama (First, Middle, Last) Pages 1 and 2 should be till ment of Health and Mental H ant: If them 27 is marked off Be HALEY, WILLIAM SR. MARY GRIFFITH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) MRS. PAM HALEY 2ND AVENUE, S.W., GLEN BURNIE, MD. 21061 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 11/15/2000 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GLEN HAVEN MEMORIAL PARK GLEN BURNIE, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, about, or near fullure. List only or a cause on each line. Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical CONCER UNINOWN PRIMARY 15 months Examiner Due to (or es a consequence of) Examine physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): Records, P.O. Box 68760. Physician/Medicai Dua to (or as a consequence of): 88 150 ŏ signed by the a Part If. Other algniffcant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? been sig Completed 24a. Was an autopsy has certificate ha 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Physician: Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes No 10 this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: Hospital or Attending Natural 5 Pending investigation death. 1 Yes 2 No 2 Accident Director: / 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Funeral Di To the Funeral Di Completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier edical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified DAVID A VAN ECHO, UD 22 South Greene Street, B-Himora, Marland 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

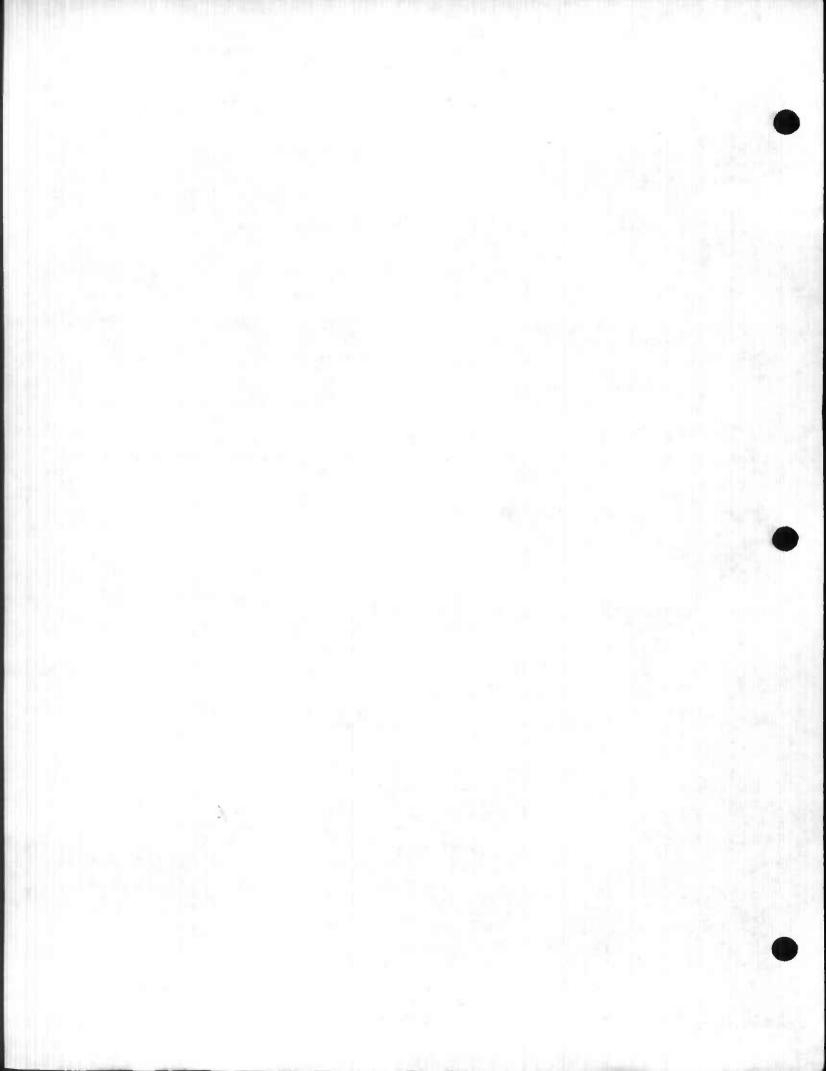
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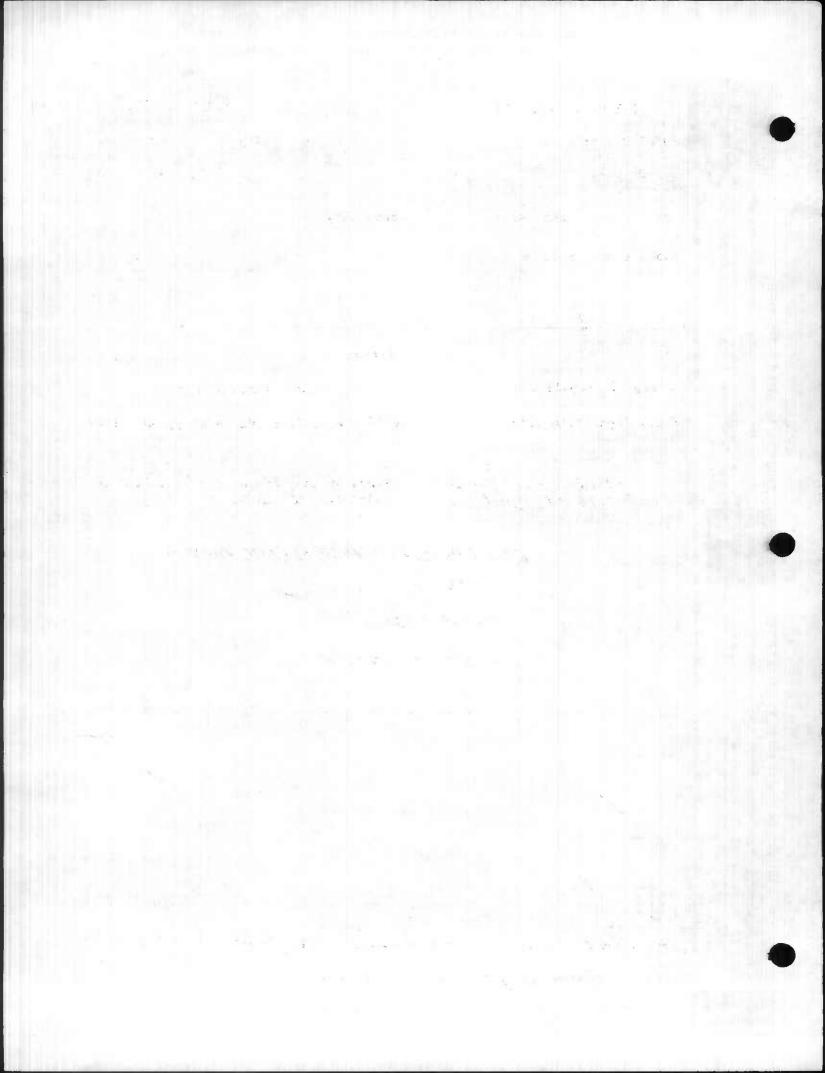
State of Maryland / Department of Health and Mental Hygiene 0 36038

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Be C		17. Father's Name (First	st, Middle, Last)						er's Name	e (First, Middle,			
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	21. Signature of Funeral Service Licenses 200-79 22. Name and Address of Facility Singleton Funeral Home, PA													
		1 Second Ave. S.W. Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between												
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State of Maryland / Department of Health and Mental Hygiene

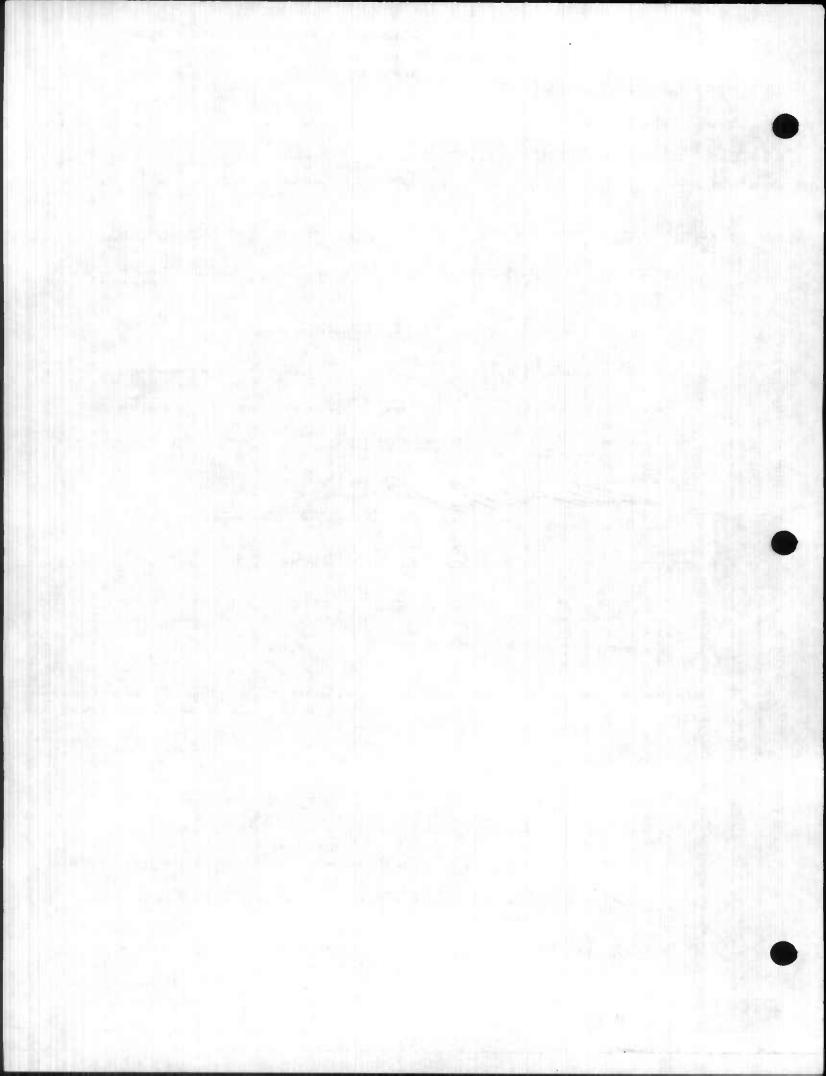
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

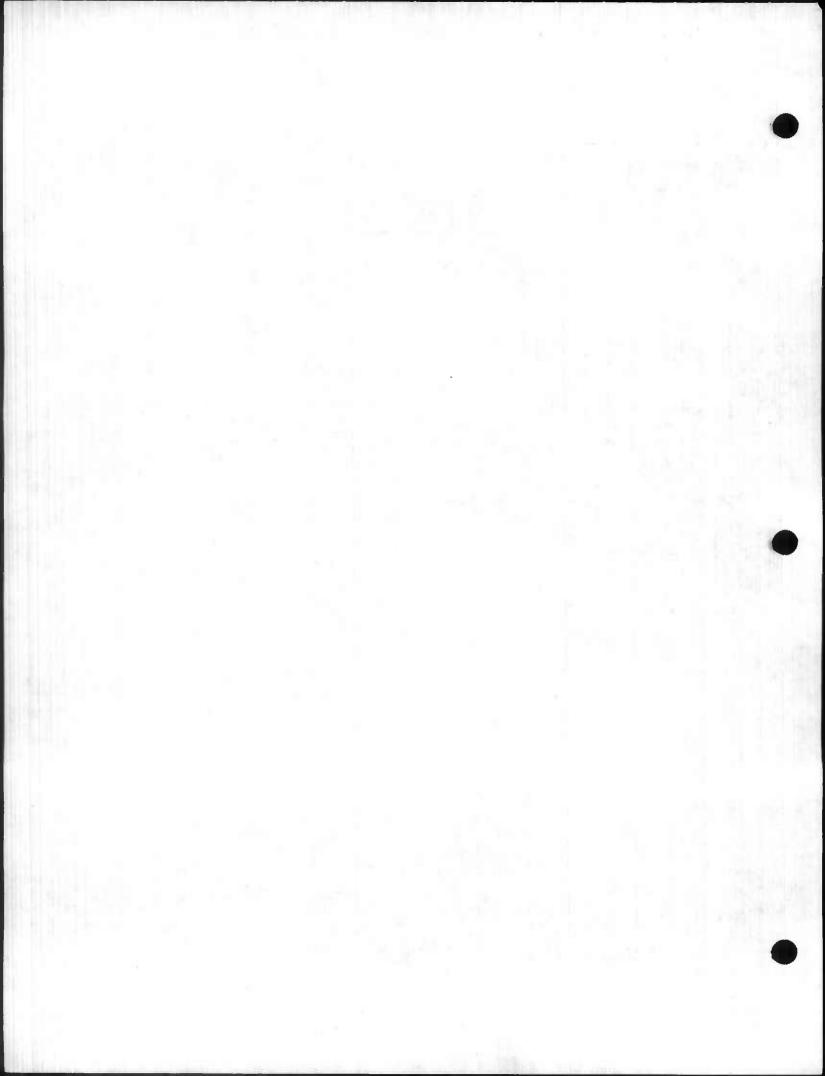
sician	Decedent's Nama (First, Middle, Last)					31	Death	2. Date of De		Veer	3. Tima of Deeth
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iedicai aminer			rive street end number)	<i>U</i>			4b. City, Town, or I			of Death	
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or	219-32-		10 M 20 F 7	4	Yrs.	5 50,5	Tiodis iviii,		,,,,,,,		raine
	Usuel Residence 10a. Stete	10b. County		10c. City	, Town or Location					1	0d. Inside City Limits
tor	MD.	N/A			BALTIMO) E					1. Yes 2□No
rec	10e. Street and N	lumber				Ip Code			10g. Citizen of \	What Cour	itry?
Funeral Director	3710 BA	YONNE AVE	FNIIF			2	1206		U.S.A		
	11. Marital Status		12. Was Decedant Armed Forces?	Evar In U,S	S. 13. Was Dec		Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No	14. Red	e - Americ	
-	1 Never Me	rried 2 Merried				2 🗆 (No		o rican, etc.,) Black, White, etc. Specify:		etc.
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	(Sp	15. Decedent's ecity only highest g	Education grade completed)		16a. Decedent's Us (Give kind of	vork done	during most of wor	orking 16b. Kind of Busi		usiness/Inc	dustry
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0 00	UNKN								e, Meldett Surneme)		
ř		Neme/Reletionship			19b. Meiling Addre	ss (Street		INKNOWN nber or Rural Route Number, City or Town, State, Zip Code)			
		IWASZKO/					AVENUE, B				0100/
X	20e. Method of Di	isposition		20b. Pl	lece of Disposition (A	eme of		Dete	20c. Location	City or To	own, State
		2 ☐ Cremation 3 5 ☐ Other (Spec	Removel from Stete					1/11/00	DALTTH	יחר ע	ADIA AND
		Funaral Service Lic		51.		and Addra	ass of Facility			KE, II	AKYLAND
	1		1	2			EILER INC				
	23e, Part1, Enter	r the diseese, or co	mplications that caused ly one cause on each lin	the deeth	1901	EASTI ode of dvi	FRN AVENU	F, BALTT	MORE, MAR	EYLAN:	Approximete
	shock, or he	eert tailure. List on	ly one ceuse on each lin	ne.							Interval Between Onset and Deeth
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	diseese or condit resulting in deeth	1)	a	101	ancreatic Curcer						
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amin	Sequentially list of	conditions,	b			t):					
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cian lical	Decedent's Name (First, Middle, L DOROTHY JOHN:	ast)	Certific			2. Date of Dec Month OCTOB		000	3. Time of Death 2140 PM
ner	4a Facility Name (If not institution, git 905 EAST PRESTON	ive street and number)			4b. City, Town, or Li BALTIMOR	ocation of Death			2140 FM
	5. Social Security Number Unik 6.	Sex 1 M 2		Inder 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, De Oct 31	1952	9. Birthplac Country)	e (State or Foreign UNK
	Usual Residence of Decedent 10a. State 10b. County MD	10c. Cit	y, Town or Location Baltimo					10d.	inside City Limits 1X Yes 2 □ No
ā	10e. Streef and Number 905 East Prestor	Street		M. Zip Code	21202		10g. Citizen of W USA	het Country	
by Funeral	11. Marital Status Unk 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? UNK 1 Yes 2 No If Yes, Give Year or Dates:		Decedent of the specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Ricen, etc.)	14. Race Blac Specify	e - American k, White, etc. blac	
Completed	15. Decadent's Elementary/Secondary (0-12)		18a. Decedent's (Give kind life. DO N	Usual Occup of work done OT use retire	during most of work	unk ing	16b. Kind of Bu	siness/Indus	try unk
2000	17. Father's Name (First, Middle, Las	unk unk			18. Mother's Nam	e (First, Middle,	Meiden Sumam	e) UI	nk
	19a. Informant's Name/Relationship O . C . M . E .	(Type, Print)			and Number or Run reet Bal				ode)
in al	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	се)	Date	20c. Location -	City or Town	, State			
	Approximate shock, or heart failure. List only one couse on each line. ACUTE PYELONEPHRITIS WITH ABSCESS FORMATION ASSOCIATED WITH FOCAL BRONCHOPNEUMONIA								
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (c	or as a consequence	e of):					
by Physician/Medical Examir	Part It Other elanificant conditions	contributing to death but not res	ulting in the under	ven in Part I.		tobacco use coi		ne cause of death?	
nysici	raitit. Other argititicant conditions						100 20140	0_110000	,
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WILLIAM KI	ONEY	State of r	Maryland / I	Certificate			ivientai ny	Reg. No.	0 3	5042
Physician	Decedent's Name (First, Middle WILLIAM K.						2. Date of Do Month OCT	Day	Year 00	. Time of Death 0819 AM
/Medical Examiner	4a Facility Name (If not institution JOHNS HOPKIN		er)	A. L.		4b. City, Town, or BALTIMO		th 4c. County	of Death	1
Funeral Director	5. Social Security Number Un	C6. Sex 1 M 2 □ F	Age (In yrs. last bii 59	thday) If Under Months Yrs.	Year Days	If Under 24 Hrs Hours Min.		rth ay, Year) 1941	9. Birthplace Country)	(State of Foreign
show show ed.at	Usual Residence of Decedent 10a. State unk 10b. County	unk	10c. City, Tow	n or Location	un	k				Inside City Limits
with the Marylar a or 28e-f show Lbs.notfilled.at		C		10f. Zip Code UNK 10g. Citizen of W						
020 urs after death w at, or flame 23a Examiner must b	3 Widowed 4 Divorced	If Yes, Give	s? □No unk	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			o- 14. Rac Bla Specifi	Race - American Indian, Black, White, etc.		
Maryland 21215-0020 d 2 should be filed within 72 hours at th and Mantal Hygiene. 77 is merited other than "natural", or traumatic event, the Medical Exam To Be Completed by F	15. Deceder (Specify only highe Elementary/Secondary (0-12)	t's Education st grade completed) College (1-4c)	16a	Decedent's Usua (Give kind of work life, DO NOT use	Occup done retire	pation during most of wo d)	rking unk	16b. Kind of B	usiness/Indus	unk unk
and 2. Ind 2. Ind 4. Ind 4. Ind 4. Ind 4. Ind 5. Ind 6. Ind 6.	unk 17. Father's Name (First, Middle,	unk Last) unk				18. Mother's Na	me (First, Middle	e, Maiden Sumar	ne)	unk
	19a. Informant's Name/Relations O.C.M.E.	hip (Type, Print)		o. Mailing Address			ural Route Numb			de)
altimore, mit. Pages 1 a partment of Hes portant: If hem y injury or othe	20a. Method of Disposition 1 Burlal 2 Cremation 4 Donation 5 Other (S		te cemete	f Disposition (Nam ry, crematory or of	e of her pla	ce)	Date	20c. Location	- City or Town	, State
Dealth Ospanit any inju	21. Signature of Funatal Service	Scanses ade, Di	rector	22 Name and State Baltin		ress of Facility Boa	rd 655	W. Balt	imore	Street
Physician	23a. Part1. Enter the disease, or shook, or heart tailure. List	complications that cause only one cause on each	sed the death. Do	not enter the mode	ot dyi	ng, such as cardia	c or respiratory	arrest,	tn'	pproximate erval Between nset and Death
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	6.	Due to (or as a	consequence of):	21	-				
6760, cate be asscuted physician and the buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b	Due to (or as a	consequence of):						
ficate ficate phys	resulting in death) Last	d	Due to (or as a	consequence of):					1	
P.O. Be that the death ad by the atterdeteched for Physicia	Part II. Other significant condition	ons contributing to death	h but not resulting	n the underlying ca	use gi	ven in Part t.		tobacco use co		e cause of death
w requires that w requires that seen signed it should be det	Atenosder	otir Gra	diovosa	inter	Dis	slope	24a. Wa	s an autopsy formed?	availa	autopsy findings ble prior to letion of cause ath?

To the Hospital or Athending Physician: The la within 24 hours effer death.

To the Funeral Director: Affer this certificate ha. Medical Certification: To Be Com Division of Vital Re filled in by

28. Place of Death (Check only one)

25. Was case referred to medical examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 No 20 ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year) 1 Natural
2 Accident 5 Pending Investigation 1 Yes 2 No 28t. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Placa of tnjury - At home, farm, street, factory, office building, etc. (Specify)

4 Homicide

29a. Certifie (Check one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signat 29c. License number

O.C.M.E

ho completed cause of death (ttem 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

DHMH 16 Rev 6/95

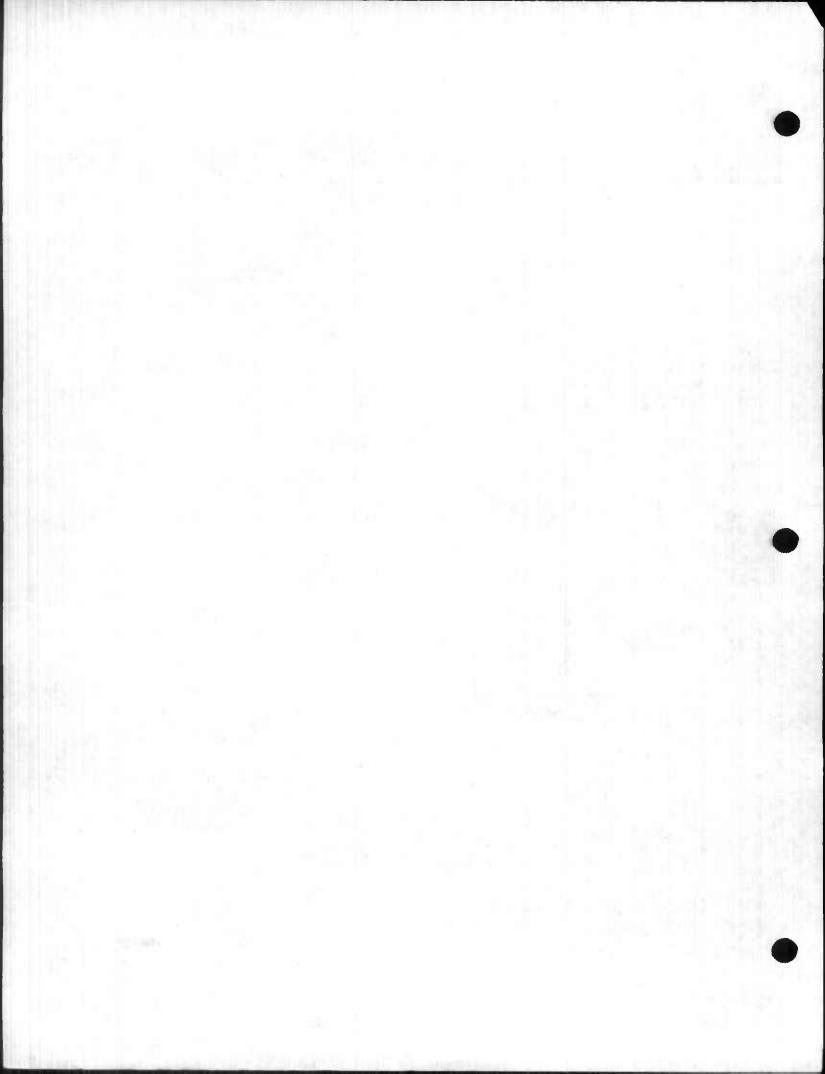
31. Date filed (Month, Day, Year)

Lockemo

32. Registrar's Signature

ORIGINAL

29d. Date signed (Month, Day, Year) OCT. 31, 2000



State of Maryland / Department of Health and Mental Hygiene AMEND ITEM: # 8 PER F.H. G. 789 11-27-00 WR. Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2 Date of Deeth Month **Physician** N. 7:30 PM LUCILLE KOBYLSKI 2000 /Medical 4a Facility Name (If not Institution, give street and number 4b. City, Town, or Location of Death 4c. County of Deeth Examiner BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Months Deys Hours Min. 10 M 20 F 227. 28.271 74 Yrs. Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTINIORE 1 Yes No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Counfry? USA Hwy. 21222 ENING 1206 Funeral 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 Yes 2 No Specify: CAUCASIA Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d Hygiene. other than Elementery/Secondary (0-12) College (1-4or 5+) 10 17. Father's Name (First, Middle, Last) Be Mental MARTIN 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Nam 27 Date 20c. Location - Ci MR. BERNARD KOBYLSKI 20c. Location - City or Town, State November Saltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Burial 2 Cremation 3 Removal from State Concion 5 Other (Specify) ъ 22. Name end Address of Facility KALZOROWSKI DUNDARK Approximate Interval Between Onset and Death 23a. Pert1. Enter the disease, or complications, or heart feilure. List only on tions that caused the deeth. Do not enter the mode of dying, such as cardiac or cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Colon Cancer Examiner Due to (or as a consequence of) Physician/Medical Examiner sician and burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initialed events resulting in death) Last Due to (or es e consequence of): physician s the burial Due to (or as a consequence of): Box Lucille Kobylski 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yss 2 No 3 Probably ¶ Unknown à 24b. Were eutopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No Vital 25. Was case referred to medical 26. Plece of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 10ther (Specify) Hospice Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA edical Certification: To 1 Yes 2 No o this 27. Menner of Deeth 28c. tnjury et Work? 28d. Describe how injury occurred After Division Hospital or Attanding 5 Pending investigation 1 Neturel 2 Accident after death.

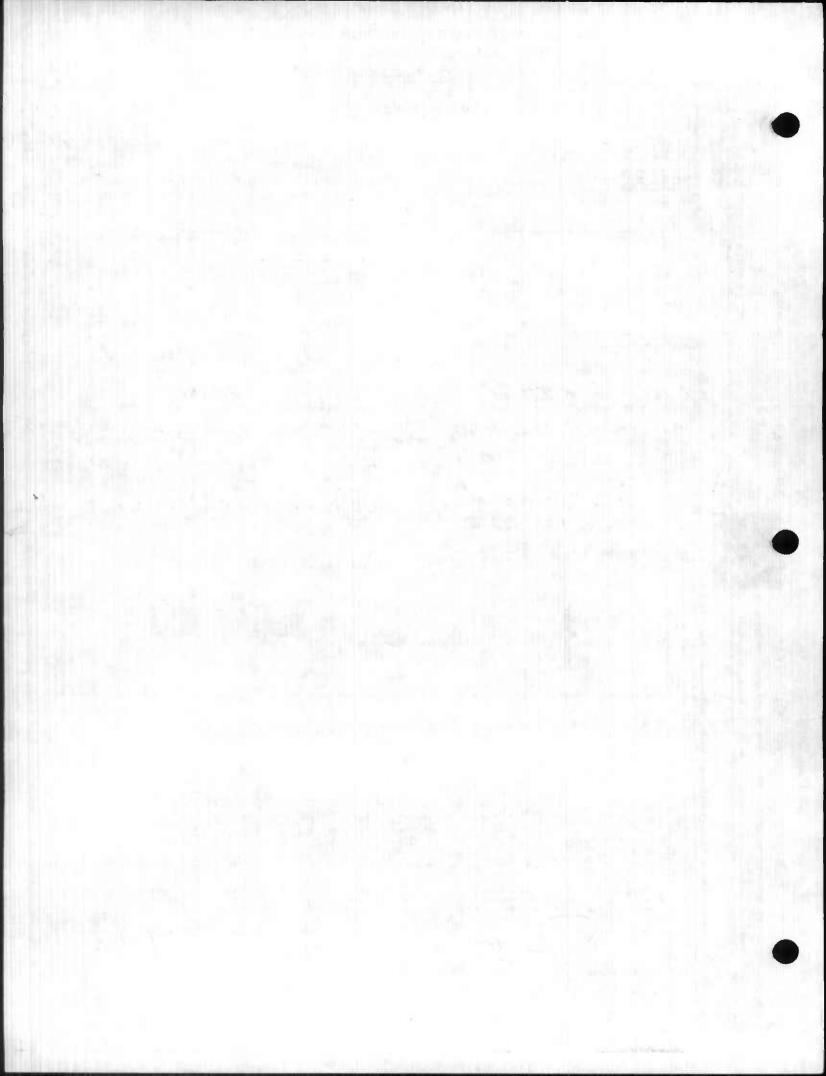
Director: After in by the further. 1 Yes 2 No 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) yd ni bellii after 4 Homicide within 24 hours a To the Funeral C completely filled 1X Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier To the 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier 00 4372 30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print) 2300 Dulaney Valley Road, Timonium, MD Dr. Tariq Mahmood, 31. Dete filed (Month, Dey, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

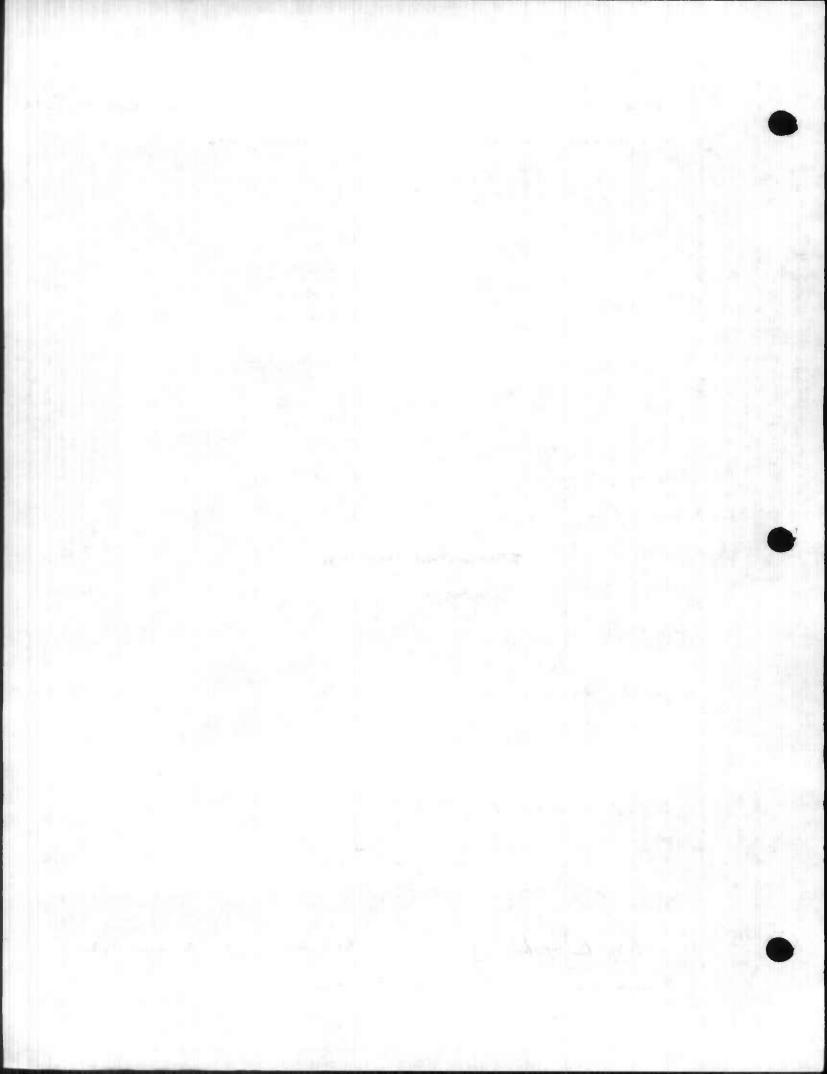
NOV 14 2000



- 1	Please Type or Print in Black Indelible ink.	
	State of Maryland / Department of He	ealth and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Deeth Year Month **Physician** SEMEN KOKOTOV 4:52 AM NOV 2000 11 /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (ff not institution, give street and number) 4c. County of Death Examiner Baltomore City Sinui Kosp. tal of Baltmore 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Ye 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months Days (Month, Day, Year) FEB. 4 1914 Hours RUSSIA Yrs. 86 217-33-2921 Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits traumetic event, the Medical Examiner must be notified at MD N/A BALTTMORE 1 TYPes 2 □ No Director 280-1 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Herne 23a or 3615 FORDS LANE APT, 614 21215 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Meritel Stetus 1 ☐ Yes 2 ☐ No 1 Never Married 2 Married 8 1 Yes 2 No Specify: Specify: WHTTE à 3 Widowed 4 □ Divorced "naturs", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) ATTORNEY AT LAW 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Merital **JOSEF** ELE KOKOTOV **AGRONOVICH** 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health an important: if them 27 is many injury or other 2006. 2700 LIGHTFOOT DRIVE BALTIMORE, MD. 21209 BORIS KOKOTOV/SON Baltimore, 20b. Place of Disposition (Name of 20e. Method of Disposition 20c. Location - City or Town, Stete BEIH TFILOH CONGREGATION 11/12/00WOODLAWN, MD. 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 21. Signature of Fundam Service License 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical Inhucerebral hemorrhage Examiner Due to (or as a consequenca of): Hy suten sion Examin attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequenca of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown signed by þ 24b. Were eutopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? Completed After this certificate hes 1 Yes 2 No 2 1 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P spital or Attending Physical strength of the physical Director: After this y filled in by the funeral di 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Netural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital
within 24 hours a
To the Funeral Completely filled Hospital 1. Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated. 29a. Certifier Wedical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES 000 November 11, 2000 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Rajiva Sinai Wospill Dochi 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 1 3 2000 Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Ann Beldovitz Lyons November 11 2000 9:45 pm /Medical 4a Facility Name (Il not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Stella Maris Hospice Timonium Baltimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Days Months Hours 1□M 2♥F Yrs Maryland **Director** 214-18-2782 93 Nov. 8, 1907 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified 1X Yes 2 No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Berrs 23a or 1820 Queen Anne Square 21015 U. S. A. Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No No H Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours after 1 Never Married 2 Married ò 21215-0020 1 ☐ Yes 2 X No Specify: Specify: by 3 Nidowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filled within il Hygiere. Elementary/Secondary (0-12) College (1-4or 5+) 2 Years Lawyer's Office Stenographer Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be Ill mart of Health and Mental H sert: If Nem 27 is marked oth lury or other traumatic even Be George Beldovitz Anna Kowalski 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Jennifer Myers (Granddaughter) 1820 Queen Anne Square, Bel Air, Maryland 21015 Baltimore, 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/15/00 Baltimore, Maryland Most Holy Redeemer 21. Signature of Funeral Service Licensee 22. Name and Address of Facility any ir Schimunek Funeral Home Inc. Made 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Pert1. Enter the disease or concein bations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. Ulft only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ACUTE MYOCARDIAL INFARCTION **Examiner** Due to (or as a consequence of): Examiner the death certificate be axecuted the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): pue Box 68760. attending physician Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): USB BS P.O. Part II. Other elamificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? GZ4212/5501 34/57/050/250355 1 Yes 2 No 3 Probably 4 Unknown The law requires that Vital Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an eutopsy performed? Completed ipital or Attending Physician: The law ours after death. eral Director: After this certificata has filled in by the funeral director, page 2 it 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 89 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ZANo Certification: To o 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 1 Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide To the Hospital of Within 24 hours af To the Funeral Di completely filled in Medicai critying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

Continued in the cause (s) and manner as stated.

Continued in the cause (s) and manner stated. 29a. Certifier (Check only one) 29b. Signature of More provider Local 29d. Date signed (Month, Day, Year) 29c. License number 11 13.00 D 15504 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) Eddie Nakhuda, M.D. 2300 Dulaney Valley Rd Timonium, Md 21093 31. Date filed (Month, Day, Year) 32, Registrar's Signature State

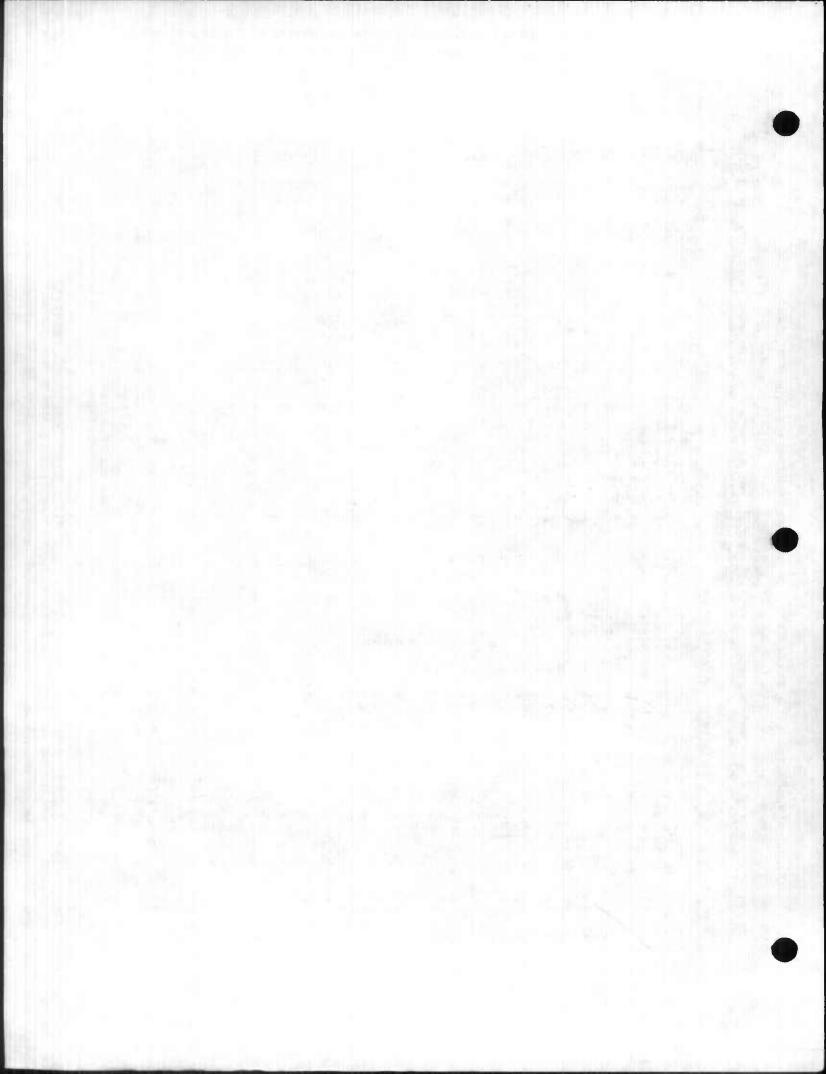
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Registrar

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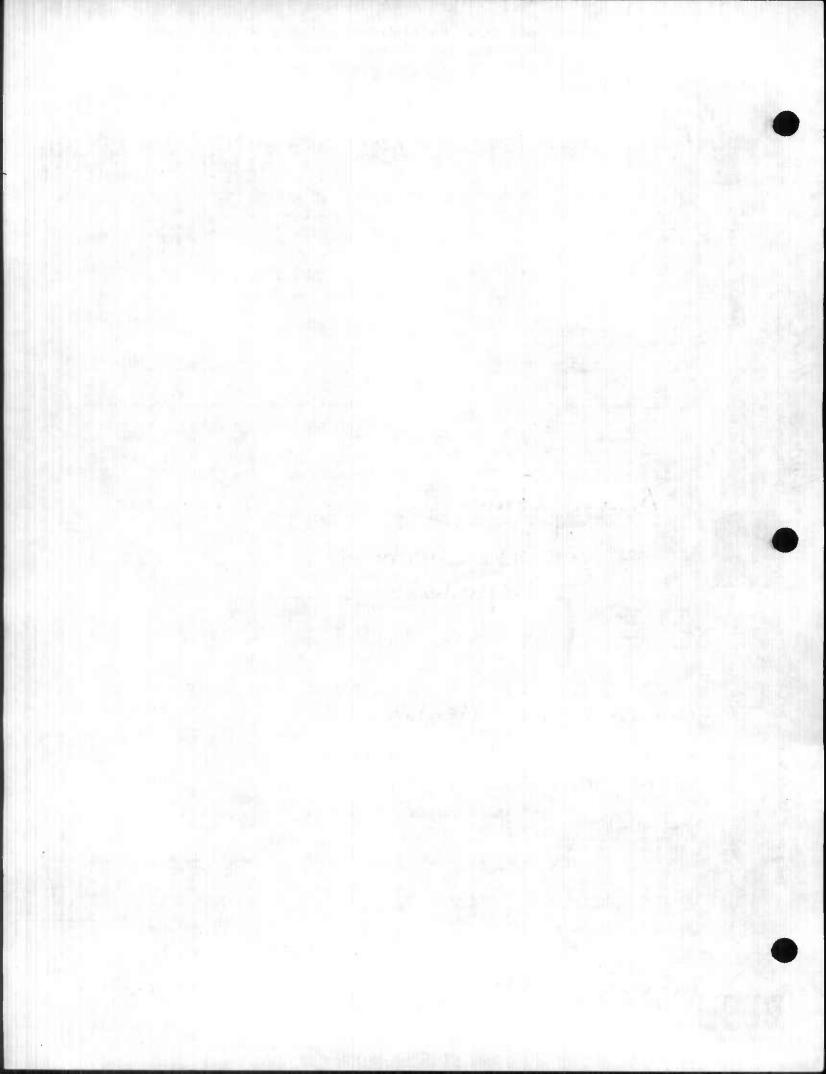


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	Decederate Name (F)	ont Middle Land	1		Certi	ficate of	Death	2. Date of D	Reg. No.		3. Time of Death
sician	I. Decedent's Name (Fir	st, Middle, Last	ANN	D I	LANGE			Month	Dey	Year	1.15 And
edical	a Facility Name (If not	institution, give					4b. City, Town, or L	ocation of Dea	th 4c. County	of Death	1.10 17/1
niner	Fra VI:	Sallar	~ Hospi	tal (00.	ter	Rose	dalo	Ba	Hin	Jano
	Sociel Security Number			ge (In yrs. las		f Under 1 Yeer	If Under 24 Hrs.	8. Dete of 8 (Month, D	rth	9. Birthpl	ace (State or Foreign
	215-40-8499	1[JM 202[F	70	Yrs.	nontris Days	TIOUIS IVIII.	Sept.	16 1930	Mary	
-	Jsual Residence of Deci Oa. State 10b	edent . County		10c City	Town or Loca	tion				10	Od. Inside City Limits
		Baltimo	ore	Too. Oity,	TOWN OF EGGG		le River				1 ☐ Yes 3€ No
Director	IOe. Street and Number					10f. Zip Code			10g. Citizen of V	What Count	ry?
2	2125 Cora	1thorn	Road			2	21220		U	SA	
1	1. Meritaf Stetus		12. Was Decedent	Ever in U,S.	. 13. Wa	s Decedent of	Hispanic Origin? (Span, Mexicen, Puert	pecify Yes or N	o- 14. Rec	e - America k, White, e	
	1 Never Married 3 Widowed 4		Armed Forces' 1 ☐ Yes 253 If Yes, Give Year or Dales:			Yes 2K No		o rican, etc.)	Specify		ite
	15. I	Decedent's Edu	icetion		16a. Deceder	it's Usuel Occu	pation	kina	16b. Kind of Bu	usiness/Ind	ustry
Paradina	Elementary/Secondary	-	College (1-4or	5+)			during most of wor	- d			
-	8th	Middle Last			Homem	aker	19 Matheda No	no (First Middle	OWI e, Maiden Suman	n home	e
	7. Father's Name (First, Walter B		nam .						o, maiden Suman	.5)	
-	19a. Informant's Name/F				19b. Mailing	Address (Stree	DOT1S	Wolfe	ber. City or Town	State. Zin	Code)
	MArtin Lan						horn Road		imore Md.		220
2	20a. Method of Disposition			20b. Pla		ion (Name of tory or other pla		Date	20c. Location -		
	1 XBurial 2 Cre 4 Donation 5 D					emetery		2000	Baltir	nore	Maryland
-	21. Signature of Funeral			. 1		lame and Addr			24202		· · · · · · · · · · · · · · · · · · ·
	DR-T		()	011.			y Funeral				
+	23a. Part1. Enter the dis shock, or heart fail	sease, or comp	lications that cause	d the deeth.	De not enter	300 MAC	e Ave. F	Baltimon or respiratory	re Md. 2	1221	Approximate
	shock, or heart fail Immediate Cause (Final disease or condition		me cause on each	ine.	mh	100					Interval Between Onset and Deeth
	resulting In death)		a. Livey	Due to (or	es a conseque	nce of):			100	1	The state of
Lyanini			Hep	atiti	5 C	_				1	
	Sequentially list condition	ons,	1	Due to (or a	as a conseque	nce of):	A Marin			1	
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	that initiated eventa resulting in death) Last			Due to (or a	as a conseque	nce of):				1	
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	2-44 000	101			Non la éta cond		in Dad f	22h Di	d tobacco use co	ntelbute to	the cause of deeth?
.	Part if. Other eignificant	Conditione co	ritiouting to death I	21 not result	ting in the und	erryrrig ceuse g	rven in Part I.		Yee 2 No		bably 4 Unknown
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-	Tac 1.	Dais	1. 10	1 10		0.11:1			s en autopsy formed?	24b. We	era autopsy findings allable prior to
	MISWIN	Depen	gent D	abet	es 1	Tell	145	poi		COF	mpletion of cause deeth?
r	mmn.	Antein	Disan	10.	Her.	erton	SIDO	10	Yes 2 No	10	Yes 2□ No
-	25. Was case referred to	medical +) There	-)	1131	_ , ,	26. Place of De	ath (Check only	one)		
	examiner?		Hospitel: 1 Hopet	ent 2 E	R/Outpalient	3□ DOA O	ther: 4 Nursing I	lome 5□Re	sidence 6 Oth	ner (Specif)	1)
2	27. Menner of Death	☐ Pending	28a. Date of Inj (Month, Di	ay Year)	28b. Time of Injury		ury at ork?	28d. Describe	how injury occur	red	
	2 Accident	Investigation				M 1	☐ Yes 2 ☐ No				
	3 ☐ Suicide 6 L 4 ☐ Homicide	Could not be determined	286. Piece of it	jury - At hom tc. (Specify)	ne, farm, stree	t, factory, office	9		(Street and Numl own, State)	ber or Rura	l Route Number,
-	200 000	0-46 1	alalan Turi	al I	ladas di it	animar di acidi	time determine	and this to it		000000000000000000000000000000000000000	atad
	29a. Certifier 1 (Check only 2)	Medical Exam	iner: On the best and manners	of examination	reage, death on and/or inve	stigation, in my	time, date and place opinion, death occu	rred at the time	e, date and place,	end due to	the cause(s)
	29b. Signature and title	of certifier	and manners	1018U.		29c. Licer	nse number	Jan 198	29d. Date signe	d (Month,	Day, Year)
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-	N Name of the last	2 1		donak da	000) (7:		1 4037	00	Noven	mber	7 2000
1	30. Name end address o	or person who c	ompleted ceuse of	coath (Item :	ZJa) (Type, Pi	(mt)	alm Ti	20 12.	Homan	000	010 423
	11. Date filed (Month, D	ay, Your)	32, Regist	rer's Signatu	ILE NOTE OF	n eju	WAS THE	ve 10	CHILONA) 110	Juna
nte rar	ar. Date fied (Month, 10	ny, ronz	32. Hegist	er a bignatu	1 4	Too	eld			-	0

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth November 2000 Hel 09:15 ease St. Eli 20 bath & 1/1 1511 City, Town, or Location of Deeth 4c. County of Death NUISING 8 T Yrs. 5. Sociel Security Number Birthplace (State or Foreign Country) 212-18-1328 10 M 20 F Months Deys Hours Maryland Usuel Residence of Decedent 10b. Count City, Town or Location 10d. Inside City Limits 1 Yes 2 No bitus More 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country 21227 nited 1260-12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Yeer or Dates: 14. Rece - American Indian, Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1□Yes 2No Specify: white 3 Widowed 4 □ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working) life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) arylano 17_Fether's Neme (First, Middle, Last) 18. Mothec's Neme (First, Middle, Meiden Sumeme) Heyers Teorge 19b. Malling Address (Street and Number or 1 daughter Braun Lease / intan 1260 2 d 20e. Method of Disposition 10 Buriel 2 Cremetion 3 R 20b. Plece of Disposition (Neme of cemetery, cremetory or other ple 3 Removel from State Memorial 21. Signature of Funeral S 23a Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respirations shock, or heart failure. List only one cause on each line. Arbutus MD21227 Approximete Intervel Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) Algheimers erTENSION Ascular 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown aucoma 24b. Were autopsy findings eveileble prior to completion of cause of death? 24a. Wes en eutopsy performed? 1 Yes 2 No

Physician /Medical Examiner

attending physician end for use as the burial-fransit

signed by t d be detach

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After

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To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A

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or Attending Physician:

Division of Vital Records, P.O. Box 68760.

permit. Pages 1 and 2.
Department of Health a Important if Item 27 is say injury or other trea

Physician

· /Medical

Examiner

10e. Stete

Director

the Medical Examiner must be notified at

8

Items 23a

"natural", or

d 2 should be filed within 72 th and Mantal Hygiene. 7 is manked other than "ne al Hygiene.

altimore, Maryland 21215-0020

Director

Funeral

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Completed

Be To

Examiner

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Certification: To

Medical

Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events that initieted events resulting in death) Lest

Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.

1 Yes 2 No

25. Wes cese referred to medical examiner?

1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28b. Time of

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Other: 28c. Injury et Work?

Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 28d. Describe how Injury occurred

26. Plece of Deeth (Check only one)

1□ Yes 2□ No 27. Manner of Deeth

5 Pending Investigation 6 ☐ Could not be 28e. Dete of Injury (Month, Dey Yeer)

1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

2 Accident

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

0054749

29d. Date signed (Month, Day, Year) 2000

Cause of death (Item 23a) (Type, Print)

10 Business 32. Registrer's Signature

Center Drive, Restectown, Mi)

State Registrar

Sec. 30 EN TE DESTROYER MENTERS OFFE Hypergans in Les phease I sussessed me is 2000 PAR W 1 2000 MINUTES AND STORY

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year R LLOYD MARRY NOVEMBER 8 2000 2227 4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE UNIVERSITY OF CITY BALTIMORR 8. Date of Birth (Month, Pay, Year) Tan. 8, 1935 MARYLAND 7. Age (In yrs. last birthday) If Undar 1 Yaar | If Under 24 Hrs. 9. Birthplaca (State or Foreign 5. Social Security Number Months Days Min. West Virginia Hours X M 20 F 213.34.1920 Usual Residence of Decedent 10d. Inside City Limits 10a. Stata 10c. City, Town or Location 10b. County Yes 2□ No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 333 Furrows Street 21223 U.S.A. 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2X☐ No If Yes, Give Yaar or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Nevar Married 2 Married Specify: White 1 ☐ Yas 2 XNo Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Security Guard Security 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fathar's Name (First, Middle, Last) Harry Thomas Lloyd Bessie Mae Shears 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) Nancy Lloyd/ Wife 333 Furrows Street Baltimore, Maryland 21223 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cramation 3 Removal from Stata Cedar Hill Cemetery 11/11/00 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Service Licensee 22. Nama and Addrass of FacilitGary L. Kaufman Funeral Home at Meadowridge Memorial Park 7250 Washington Blvd. Elkridge, Maryland 21075 English the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrast, the art fallura. List only one cause on each line. Approximata interval Between Onset and Death Immediata Cause (Final turnty years CONGESTIVE MEART FAILURE disease or condition resulting in death) Dua to (or as a consequence of) CORONARY DISEASE ARTERY Sequentially list conditions, if any, laading to immediate cause. Enter Undarlying Cause (Disease or Injury that initiated events resulting in daath) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contributs to the cause of death? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Piace of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 5 Pending invastigation 1 Yes 2 No

attending physician and for use as the bunal-transit The law requires that the death certificate be executed Records, P.O. Box 68760 signed by the a should b page 2 s certificate Division of Vital Physician: director this funeral To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral

Physician

/Medical

Examiner

Funeral

Director

tems 23a or 28a-f show ther must be notified at

"natural", or thems ledical Examiner in

The Medical

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Physician /Medical

Examiner

Examine

Physician/Medical

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Completed

Be

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Certification:

edicai

Baltimore, Maryland 21215-0036

Director

Funeral

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25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death Natural 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 6 Could not be datermined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifler

(Check only one) 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Mathe Hum

Medical Doctor

AU4176 435K 11614

NWEMBER, B, 2000

21213

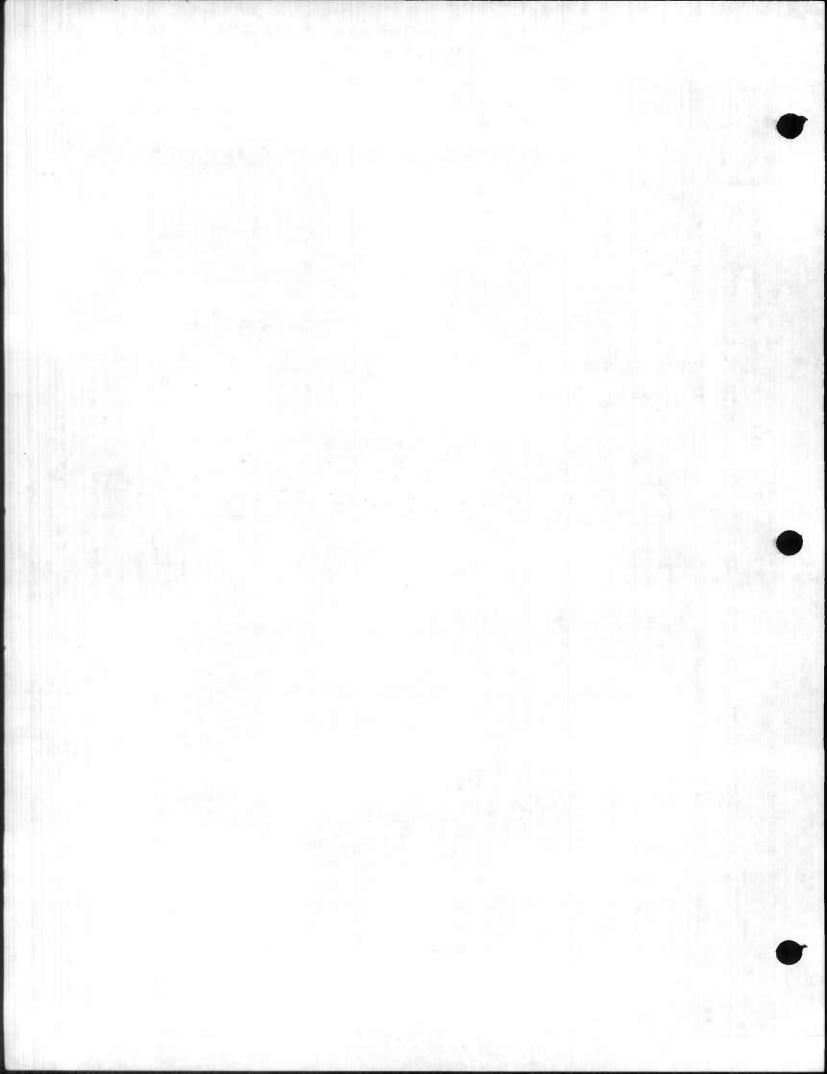
30. Name and addrass of person who completed cause of daath (Item 23a) (Type, Print) 22 South GREENE STREET BALTIMORE, MARYLAND MATHEW HERNANDEZ

State Registrar

31. Data filed (Month, Day, Year) NOV 1 4 2000

32. Registrar's Signatura LANGE !

Books



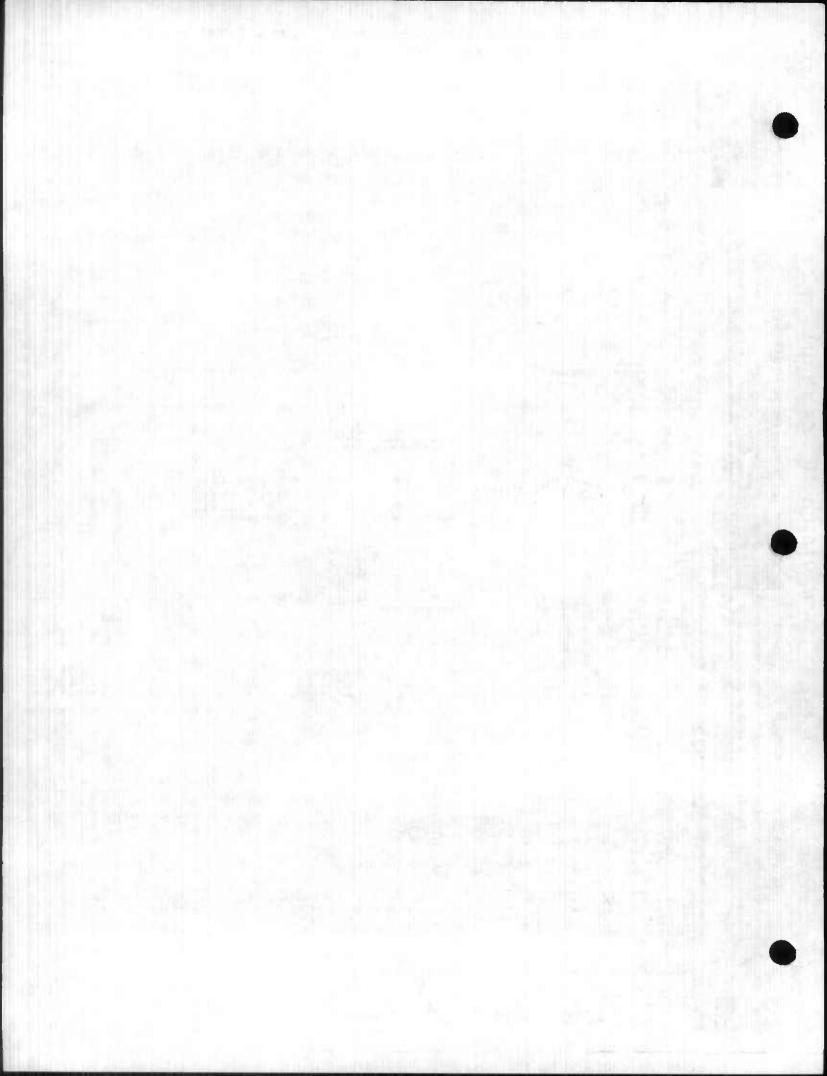
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	1. Decedent's Neme (First, Middle, L	ast)				2. Dete of Deet		3. Time of Death
ician	Loretta Cecilia	Hartley Io	WA			November		
dical niner	4a Facility Name (If not institution, gr		V.C		4b. City, Town, or		4c. County o	
ICI	Od I alanda to II and						Baltin	moro
	Gilchrist Hospi 5. Social Security Number 6.		(In yrs. last birthday)	If Under 1 Yes				Birthplace (State or Fore Country)
	218-18-7204 Usuel Residence of Decedent	1□м 2Ҋ҈Г	79 Yrs.	Months Dey	s Hours Min.	FEB 15,		Maryland
	10a. Stete 10b. County		10c. City, Town or Loc	cation				10d. Inside City Lim
0	Maryland Harford		Abingdor					1 □ Yes 2 🕅
Funeral Director	10e. Street and Number		ADITIGUOL	.I 10f. Zip Code	E OF	10	g. Citizen of W	het Country?
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0	11. Marital Stetus	Apt #C	ver in U.S. 13 V	21009		Specify Yes or No-	USA 14. Baca	- American Indian,
		Armed Forces? 1 Yes 2 No	1	Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puer o Specify:	to Rican, etc.)	Bleck Specify:	K, White, etc.
	3 XWidowed 4 □ Divorced	Yeer or Detes:					0 10 1 15	White
919	15. Decedent's E (Specify only highest go	ducation rade completed)	16a. Deced	lent's Usuel Occ kind of work don	upetion e during most of wo red)	orking	6b. Kind of Bus	liness/industry
Completed	Elementery/Secondery (0-12)	College (1-4or 5+)					
		<u>Z</u>	Admi	inistrat		me (First, Middle, A	Hospita	
8							reideri Surriame	,
9	, ,,				Julia N			
	19e. Informent's Name/Relationship	(Type, Print)	19b. Meilin	g Address (Stre	et end Number or R	lural Route Number,	City or Town, S	State, Zip Code)
	Cecelia Beatrice	Rapson/Daug	hter 3872	Swift F	un Drive	Abingdo		21009
	20e. Method of Disposition 1 Burial 2 Cremation 3	Removel from State	20b. Plece of Dispos cemetery, crem	sition (Neme of ne <i>tory</i> or other p	lace)	Dete	20c. Location - 0	City or Town, Stete
	4 Donetion 5 Other (Spec	ify)	Metro Cr	rematory	Inc.	11-10-0) Balt	imore, MD
	21. Signeture of Funerel Service Lin	energy (22	. Name end Add	ress of Facility			
	> Similar	1 AJUNAUX				of MD, In		04.000
	23a. Part1. Enter the disease, or cor shock, or heart feilure. List only	nat.d	he deeth. Do not ente	er the mode of d	rick Roac	1 Baltin	nore, M	D 21228 Approximate
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	diseese or condition resulting in death)	a	ESKD					Week
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듣		b	nio-pet	C Hy	poglyc	emic	Inen.	r week
Examiner	Sequentially list conditions, if any, leeding to immediate	D	ue to (or as e conseq	uence of):				
	Cause (Diseese or Injury	C	Sepsis					week
2		D	ue to (or es e consequ	uenca of):				
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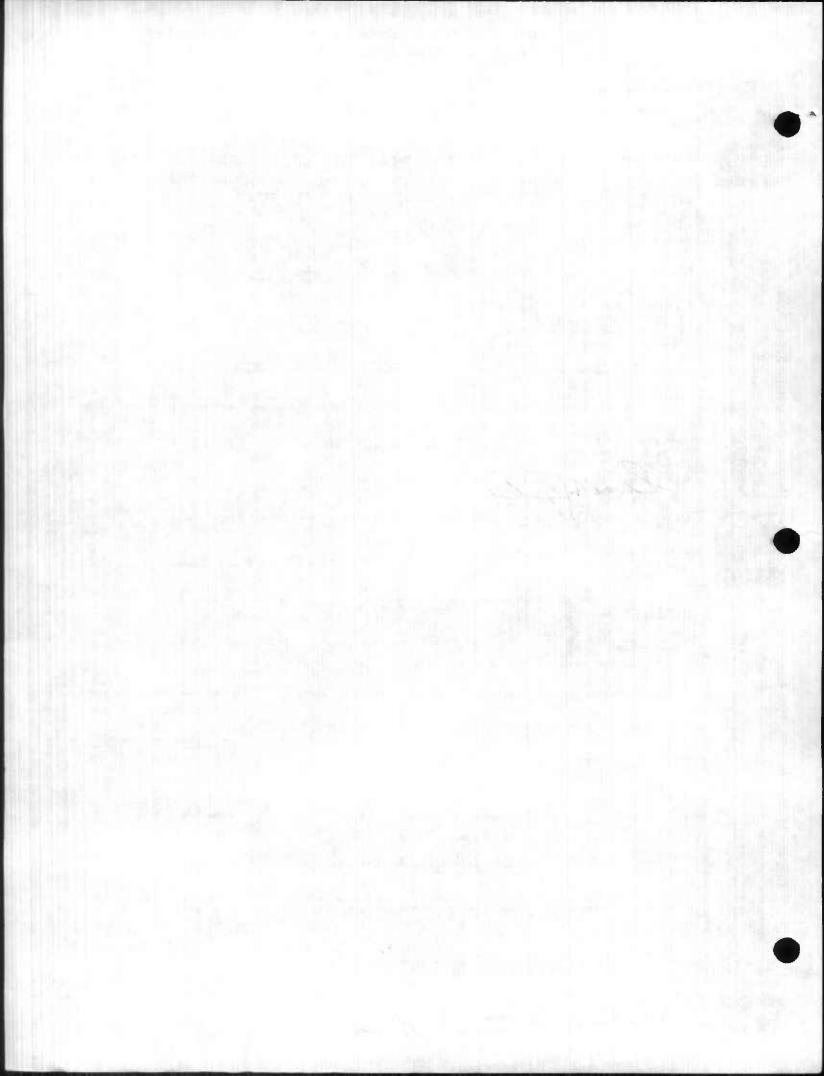
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State of Maryland / Department of Health and Mental Hygiene

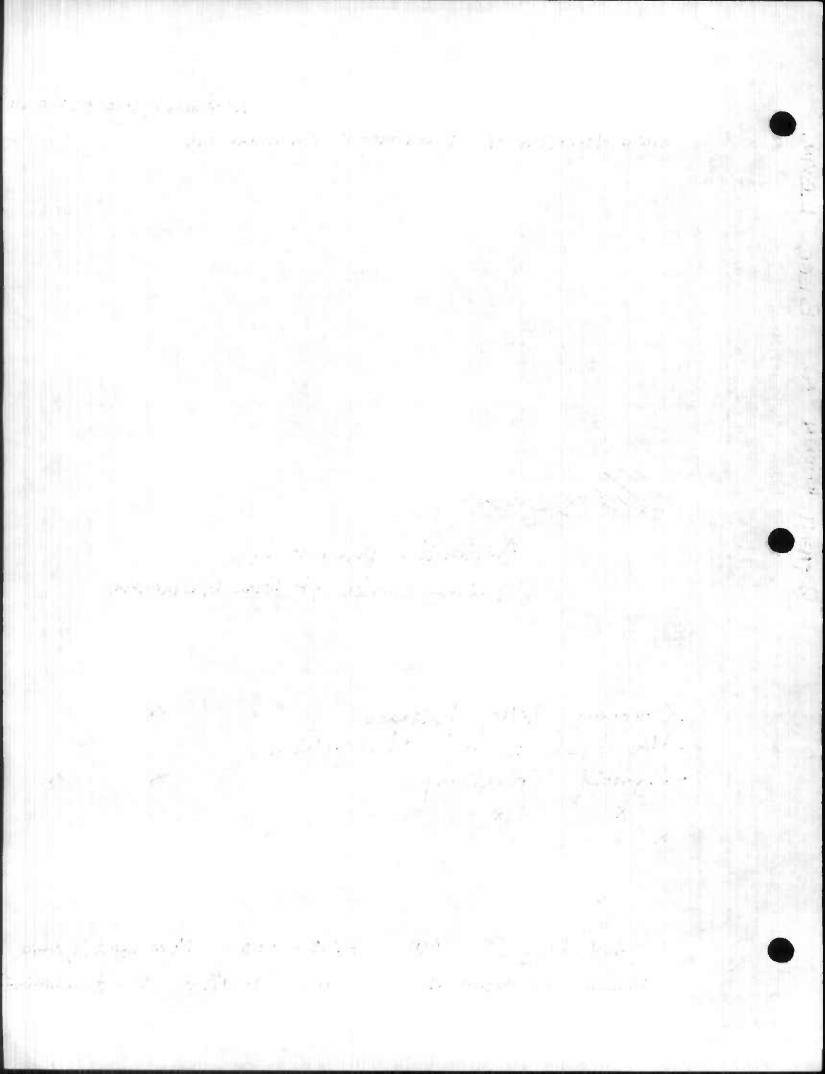
				Certifica	te of	Death		Reg. No.	U	36030
21	1. Decedent's Neme (First, Middle, Li	est)		Tally and			2. Dete of Dee	eth Day	Year	3. Tima of Death
Physician /Medical	Dorothy Lee Lew	is					Novembe		000	9:30 AM
Examiner	4a Facility Name (If not institution, gir	ve street end number)			4	4b. City, Town, or	Location of Death	4c. County	of Death	
	1615 Cliff Drive					Mayo		Anne		
uneral		Sex 7. Age 1 M 2 DXF	(In yrs. last bir	Yrs. If Und	er 1 Year Deys	Hours Min	(Month, De	h v. Year)	9. Birth	place (State or Foreigntry)
rector	579-32-0811 Usuel Residence of Decedent		73	113.			MAR 25,	1927	Wash	ington D.(
Examiner must be notified at	10a. Stete 10b. County		10c. City, Tow	n or Location						10d. Inside City Limits
Po	Maryland Anne Ar	ındel	Mayo							1 Yes 2 No
Funeral Director	10e. Street and Number	ander	layo	10f. 2	ip Code			10g. Citizen of 1	Whet Cou	ntry?
0	1615 Cliff Drive			2	1106			USA		
Jers	11. Maritai Status	12. Was Decedent E	ever in U,S.			lispenic Origin? (Specify Yes or No- rto Rican, etc.)		e - Ameri	cen Indien,
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by	3 Widowed 4 Divorced	Yes, Give Yeer or Detes:		1 Hes	2 🛚 No	Specify:		Specify	/:	White
Completed	15. Decedent's E (Specify only highest gr		16a.	Decedent's Us	uei Occup	pation during most of we	orkina	16b. Kind of B	usiness/In	ndustry
nple	Eiementery/Secondery (0-12)	College (1-4or 5	+)	life. DO NOT	use retired	d)				
S		2	Adn	ninistr	ative	Assista		Dept. o		e Navy
Be	17. Father's Neme (First, Middle, Las	1)				18. Mother's Ne	eme (First, Middle,	Maiden Sumen	10)	
9	Loren Lee Landman						Celeste			
	19e. Informant's Neme/Reletionship						Aural Route Number		Stete, Zij	o Code)
	Lloyd F. Lewis/H	usband		DID CIT:		ive May	O, MD 2	1106	City or T	oum Ctate
	20a. Method of Disposition 1 ☐ Burlat 2 ☒ Cremation 3 [Removel from State	cemete	ry, cremetory o	r other plea	<i>'</i>		20c. Location	City or 1	OWII, Stella
	4 Donetien 5 Other (Special	-	l l				11-13-0	0 Bal	timo	re, MD
ġ	21. Signature of Funeral Service Line	150		Crema	end Addre	ss of Facility Society	of MD,	Inc.		
	Edward A. Gre	orchik?		299 1	Frede	rick Roa	ad Balti	more, M	D 2	1228
	23a. Part1. Enter the disease, or con shock, or heert feilure. List only	pications thet caused one ceuse on each iin	the death. Do	not enter the m	ode of dyir	ng, such as cardie	ec or respiretory e	rest,	1	Approximate Interval Between
				^					1	Onset and Deeth
	Immediate Cause (Finel disease or condition resulting in death)	· CANC	3n e	FB.	1121	157			1	MYRS
	resulting in death)	v=1/01 +81	Due to (or es a	consequence o	t):				1	
Examiner		b							i	
xar	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or es e	consequence o	t):				1	
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edical	resulting in death) Last		Due to (or as e o	consequence o).					
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SICIB	Pert II. Other significant conditions	contributing to death bu	it not resulting in	n the underlying	ceuse giv	ven in Pert I.	23b. Did	tobacco use co	ntribute 1	to the cause of death
Physician/M							10	Yse 25 No	3 Pro	bably 4 Unknow
by F										
8								an autopsy	81	Vere autopsy findings vallable prior to
D									of	ompletion of cause I death?
Completed							10	Yes ZINO	1	☐ Yes 2☐ No
Be	25. Wes case referred to medical					26. Plece of De	eeth (Check only o	one)		
To	exeminer?	Hospitel: 1 ☐ Inpatie	nt 2 ER/Ou	utpetient 3	DOA Oth	ner: 4 Nursing	Home 5 Resi	dence 6 Ott	ner (Speci	ify)
	27. Manner of Death 1/ DNatural 5 Pending	28e. Dete of Injur (Month, Dey		Time of	28c. Inju	ry et rk?	28d. Describe	how injury occur	red	
Certification:	2 ☐ Accident investigetic			М	10	Yes 2 □ No				
E E	3 Suicide 6 Could not to determined		ry - At home, te . (Specify)	erm, street, fact	ory, office		28f. Location (. City or Tox	Street and Num: vn, Stete)	ber or Rui	ral Route Number,
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edical	(Check only 2 Medical Exa	nysician: To the best of miner: On the basis of	examinetion en	dor investigeti	ed et the tir	me, dete end pled opinion, deeth occ	ce, end due to the curred at the time,	ceuse(s) end m dete end place,	anner as end due	stated. to the cause(s)
Med	one) 29b. Signature and title of certifier	and manner ste	ted.		9c. Licens	e number		29d. Date signe	d (Month	Day Year)
	· Mille				To	2118		1	/	
	11/1001	mm			100	2110		11/13/	20	
	30. Neme and address of person who	completed cause of de	eath (Item 23e)		920	+ PAGG	THAITE	= no	A	WW. MC
)(1000 PB/ W	AT RIVE) dil i	M	100	1/40	10100	17	10	2/40
tate	NOV 1 4 2000	32. Hegistre	r's Signeture	,						



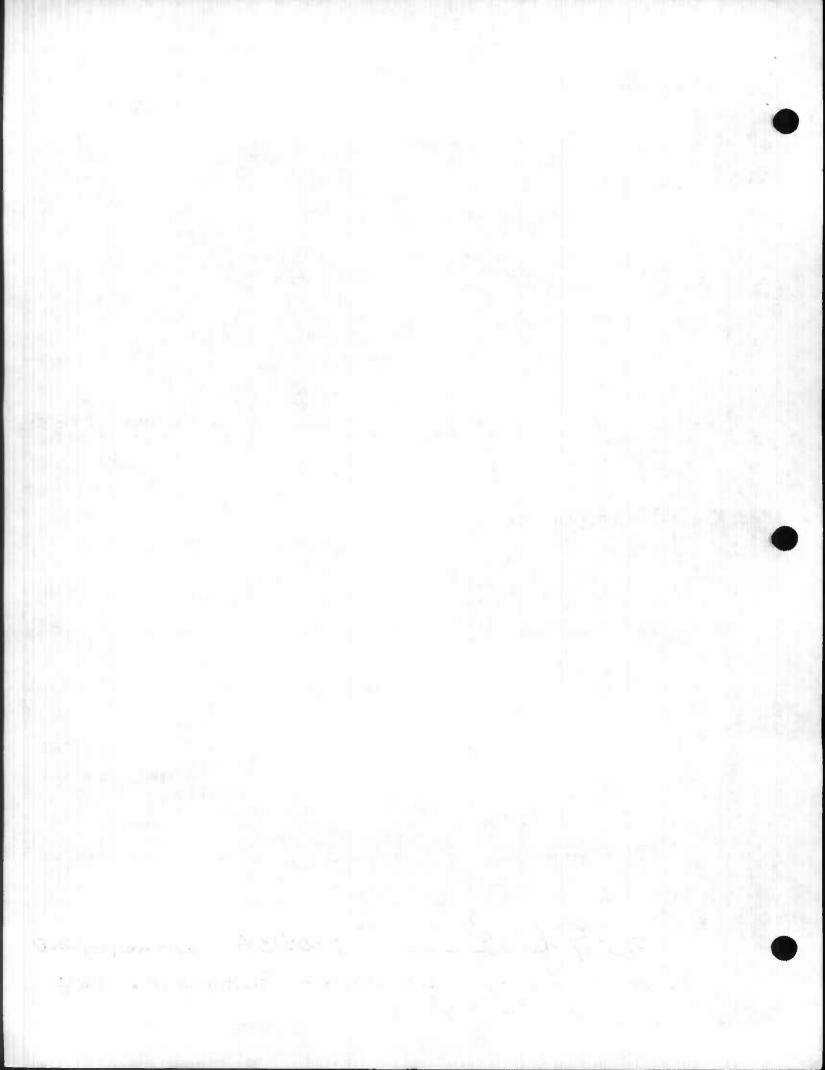
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Day Month Vaar **Physician** 02:30 AM NOVEMBER 11 2000 BEBE LEVIN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) Examiner BALTIMORE City BALTIMORE HOSPITAL OF 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs.

77 Yrs Months Days Hours Min. Birthplace (State or Foraign Country)
 MD 5. Social Security Number **Funeral** 219-16-9314 1 □ M 2 X F Director Usual Residence of Deceden the Maryland 10b. County 10c. City, Town or Location 10d. Insida City Limits 10a State 28a-f ahow MD BALTIMORE BALTIMORE 1 ☐ Yas 2 ☑ No Director 10e, Street and Number 10f. Zlo Code 10g. Citizen of What Country? ò 3218 SMITH AVE. 21208 Nerns 23s USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Yaar or Datas: 14. Race - American Indian, 11. Marital Status Black, Whita, etc. 1 □ Never Married 2 □ Married Maryland 21215-0020 1 ☐ Yes 2 No Specify. Specify: WHITE þ 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMWMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Fathar's Nama (First, Middle, Last) Be 2 should be fand Mental I HARRY ROSEN is marked REBECCA **ACKERMAN** 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2.1
Department of Health at Important: If Hem 27 is any injury or other trauponce. MRS. DONNA WEISS/DAUGHTER SPRINGBRIAR LANE BALTIMORE, MD. 21208 KNON Saitimore. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State cemetery, cremetory or other place)
BETH JACOB CONGREGATION 11/12/00 FINKSBURG, MD. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD.21208 Part I. Enter the disease, or complication of at ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cade on each line. Approximate Intervel Between Onset and Death PATIENT Physician Immediate Cause (Final disaese or condition resulting in death) /Medical Examiner Examiner sician and burial-transit Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Last Due to (or as a consequence of physician Box 68760 Physician/Medical Due to (or as a consequence of) P.O. Pert It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown yd bengis DYONAY Division of Vital Records. by 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Sigmoid 2010 1 Yes 25. Was case referred to medice! 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Patter death. 1 Natural 5 Pending Investigation Injury 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital within 24 hours a To the Funeral Completely filled **18. Certifying** Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) 29d. Data signad (Month, Day, Year) 29b. Signature and title of certified 29c. License number MD NOVEMBER 11, 4000 000 30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print) HOSPITAL KHAN, MD FAISAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 1 3 2000 **DHMH 16 Rev 6/95 ORIGINAL**



1. [D#9,21,&29D PER MD. G7 Decedent's Neme (First, Middle, Last)	789 11-14-2000 JA	B Certifica	ate of Death	2. Date of De	Reg. No.	3. Time of Deat
ian ical	VityRa		McP	onald	Septe	nber 6, 20	000 20:50
5. S	N/A	ns Hospit		der 1 Yeer If Under 24 Hrs	8. Date of Bill	m 9.	Birthplace (State or For Country)
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io t	MD. Washing	atox H	agerst	Nwo			1 □ Yes 2 🗙
10e	a. Street and Number			Zip Code		10g. Citizen of What	
2	23 AA KOSS	Street		21740		45	
Fur	Meritel Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced	2. Wes Decedent Ever in U, Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Dates:	If Yes, s	cedent of Hispanic Origin? (: pecify Cuben, Mexican, Pue 2 No Specify:	Specify Yes or No rto Rican, etc.)		Vhite, etc.
	15. Decedent's Educ	ation	16a. Decedent's U	suel Occupation work done during most of we	odkina	16b. Kind of Busine	ess/Industry
5	Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	life. DO NOT	(use retired)		NIA	
m l	Fether's Neme (First, Middle, Last)			18. Mothers Ne	ome (First, Middle	Maiden Sumame)	
	e. Informent's Neme/Reletionship (Typ	pe, Print)	19b. Mailing Addre	ess (Street and Number or F	Rurel Route Numb		
N		E/Mother	223 A	A ROSS	St. Ha	gerstown	,MS. 2174
206	e. Method of Disposition	CA	ece of Disposition (I	Verne of	Dete	20c. Location - City	or Town, Stete
	1 ☐ Buriel 2 ☐ Cremation 3 ☐ Re 4 ☐ Donetion 5 ☐ Other (Specify)	Disposal Jo	hn Hopki	ns Hospital	9/7/00	BAlto. 1	40.
21.	. Signeture of Funeral Service License	6		and Address of Fecility			0 (1 2 :20
	RAYMOND JOHNSON	(PER D.V.R.)	John	Hopkins Ho	spital	600 N WOI	fe St. 2128
	a. Pert1. Enter the disease, or complic shock, or heert leilure. List only on	cations that caused the deeth e cause on each line.	. Do not enter the m	ode of dying, such es cardie	ec or respiretory e	errest,	Approximate tnterval Between Onset and Deat!
dis	mediate Ceuse (Final eese or condition sulting in deeth)	Pulmon A. Due to (or	ry Hyr	poplasia	533		21 days
ě		Severe P			986 5	yndrome	21 00
Examiner Examiner	quentielly list conditions, iny, leeding to immediate use. Enter Underlying		es e consequenca		C33 C	910910010	900
W 36	ny, leading to immediate	air leak	SUNdr	OMe			5 day
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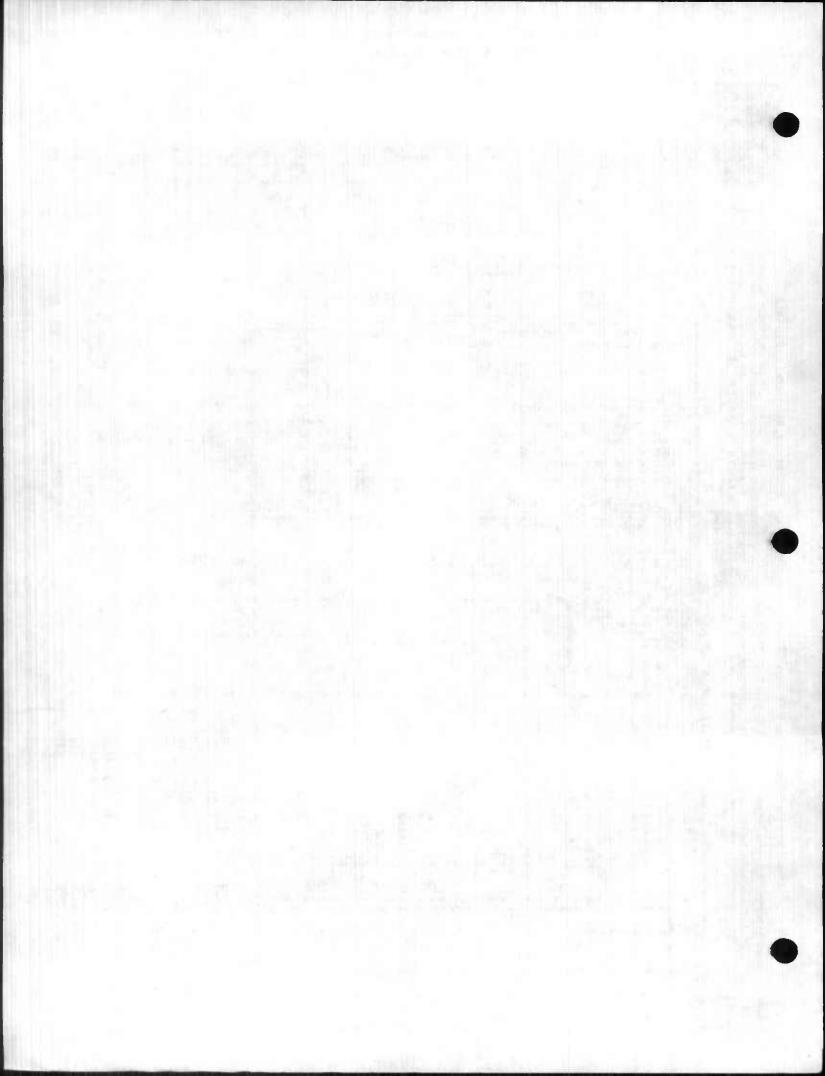


State of Maryland

/ Department of Health and Me	ental Hygiene	3605
Certificate of Death	Reg No	

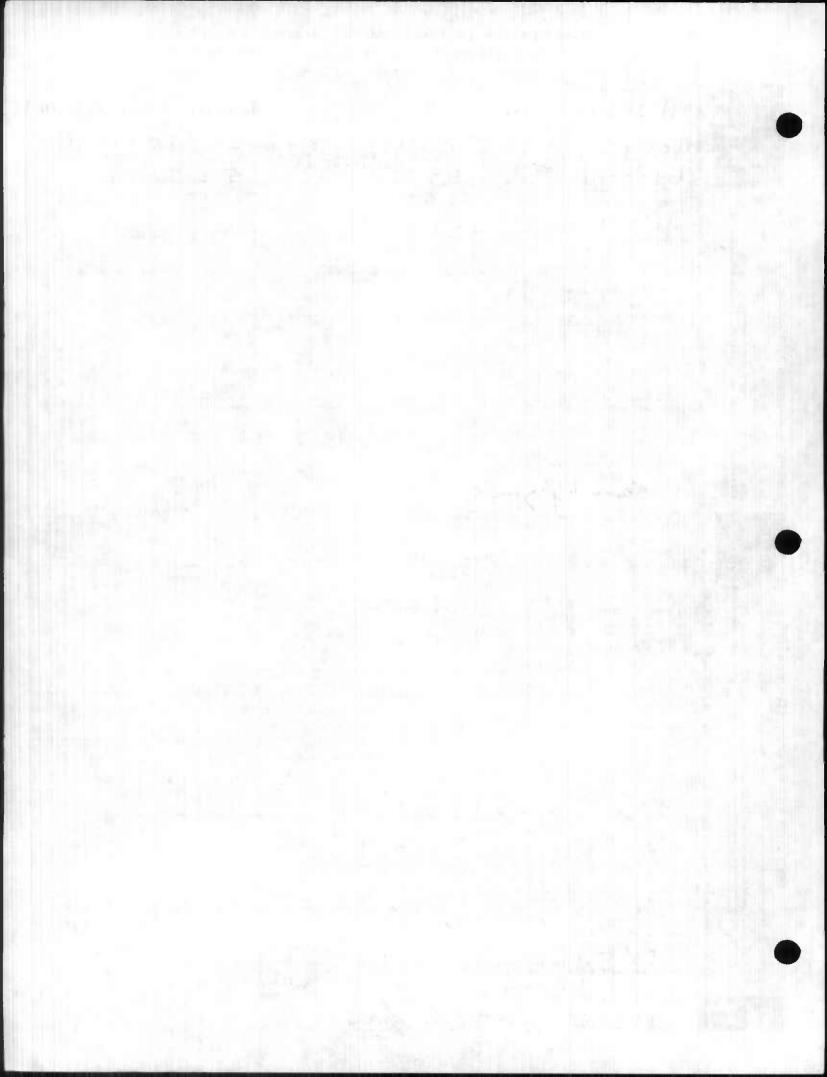
shle	y Nicole	Mason			Cert	tificate	of D	eath	F	Reg. No.				
		Decedent's Name (First, Middle, Last)								2. Date of Deeth Month Day Yeer 3. Time of Death				
	Physician /Medical	Ashley Nicole Mason							Novembe		000	10:50 AM		
	Examiner	4a Facility Name (If not instituti	on, give street end nun	nber)			4b.	City, Town, or L	ocation of Death					
		IN REAR OF 91	70 OLD ANNA	APOLIS ROA	AD			COLUMBI		HOW	ARD			
Enucration of the Maryland Director		5. Social Security Number 242–49–2736	8. Sex 1 ☐ M 2 ☐ X F	7. Age (In yrs. last b	le (In yrs. last birthday) fi Under 1 Yeer if Under 24 Hrs. Months Deys Hours Min.			(Month, Da)	ete of Birth fonth, Day, Year) R 21, 1986 Maryland					
	2 3	Usual Residence of Decedent 10a. Stete 10b. Count	v	10c. City, To	wn or Loc	ation			10d. Inside City Limits					
	lanyti Or	MD Howai	nbia					1 ☐ Yes 2 ☒ No						
	the the N	10e. Street and Number	.u	COLUM	шта	10f. Zip Co	ode			10g. Citizen of	What Cour	ntry?		
	The Part of	8585 Black St	ar Circle			2104				USA				
21215-0020 d within 72 hours after death with the Maryland	frer death with the Ma ther must be notified funer must be notified Funeral Director	11. Meritel Stetus	12. Wes Dece					penic Origin? (Sp	pecify Yes or No-			lace - American Indien, leck, White, etc. city: White		
	al', or home Lamber on by Funer	1 Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	rried 1 ☐ Yes If Yes, Giv	Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		13. Wes Decedent of Hispenic Origin? (Spiff Yes, specify Cuban, Mexican, Puerto			o Ricen, etc.)					
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Ma	d 2 sho th and 7 is m traum	Crystal Mason							, Columb					
e,	ges 1 and 2 should be flied to f Health and Mental Hyg if Hem 27 is marked other or other traumatic event,	20a. Method of Disposition	THO CITCL						Date	20c. Location				
	and	1 Buriel 2 Cremetion 3 Removel from State 4 Donetlon 5 Other (Specify) Cemetery, cremetory or other place) Meadowridge Memorial Park						al Park	11/08/00	Elkr	idge,	Md.		
Balt permit.	Departiment Important Impo	21. Signeture of Funeral Service Licensee Mog K. Moustal 22. Name and Address of Fecility Gary L. Kaufman Funeral Home @ Meadowridge MP 7250 Washington Blvd., Elkridge, Md. 21075									idge MP, Inc			
		23a. Pert1. Enter the diseese, shock, or heert failure. Lis	or complications that cost only one cause on e	aused the deeth. Do	o not ente	r the mode o	f dying,	such es cardiec	or respirelory ar	rest,		Approximate Interval Between		
40	Physician /Medical Examiner	Immediate Cause (Finel disease or condition resulting in death)	. 1	LTIPLE ST	AB U	Jourd						Onset and Deeth		
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	icate be executed physician and s the burial-transit edical Examir	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury												
x 687	5 0 4	resulting in death) Lest Due to (or as a consequence of):												
Box	es that the death certified by the attending be detached for use a by Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.						23b. Did t	obacco use co	ntribute to	o the cause of death?			
0	by the tache	Faith. Other arginiteans continuous continuous to death but not resulting in the underlying couse given in Faith.					1 Yes 25 No 3 Probably 4 Unkno							
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in of Vital Recording Physician: The law require	seen s should thould							24e. Wes en autopsy performed?		av	ere autopsy tindings reliable prior to impletion of cause death?			
	The law ate has page 2								126	es 2□No	17	Yes 2 No		
	certificate rector, pag	25. Was case referred to medic	el					26. Plece of Dec	eth (Check only o	ne)				
	this certifical director,	examiner? NCXYes 2□ No	Hospitel:	npatient 2 ER/C	Outpatient	3□ DOA	Other		ome 5 Resid		ner (Specif	W SCENE		
	After th funeral	27. Menner of Death 1 ☐ Neturel 5 ☐ Pend	28a. Dete (28a. Dete of Injury 28b. Time of (Good) 28c. fnjury at Injury Work?						28d. Describe how injury occurred				
	ris after death. "al Director: After t led in by the funers Certification:	2 Accident Inves	tigetion 1130	10:45A M 10 Yes 2000					SUBJECT STABBED And STRAIGHT					
Ž.	or Attenda after death. Director: A I in by the it ertificati	3 Suicide 6 Could deter	mined 288. Place	building, etc. (Specify)					28f. Location (Street end Number or Rural Route Num City or Town, State) REAR of 9170 Old			Noute Number,		
0	C S S S S S S S S S S S S S S S S S S S		PARKING LOT						ANNAPOLIS ROAD, Ellicott city, MD					
	n 24 hound he Funer pletely fill	29e. Certifier (Check only one) 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause (s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause and manner stated.												
	To the Hospital or Affective Within 24 hours and Affective: To the Euroral Director: completely filled in by the Medical Certifical	29b. Signature and title of ceptifier 29c. License number							29d. Date signed (Monti			Day, Year)		
	8 4 € 4		I and The											
		20 Name and address of	1/11.					C.M.E.		NOVEMBER 4, 2000				
	(V)	30. Neme and address of person	n who completed caus	o or deeth (Item 23a			C+-	mot B-	1+ima	Marril	c form	1201		
	State	31. Date filed (Month, Dey, Yea		egistrer's Signeture	111	Penn	SUL	eet, Ba	ltimore,	Maryla	and 2	1201		
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Registrar DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 00 36054

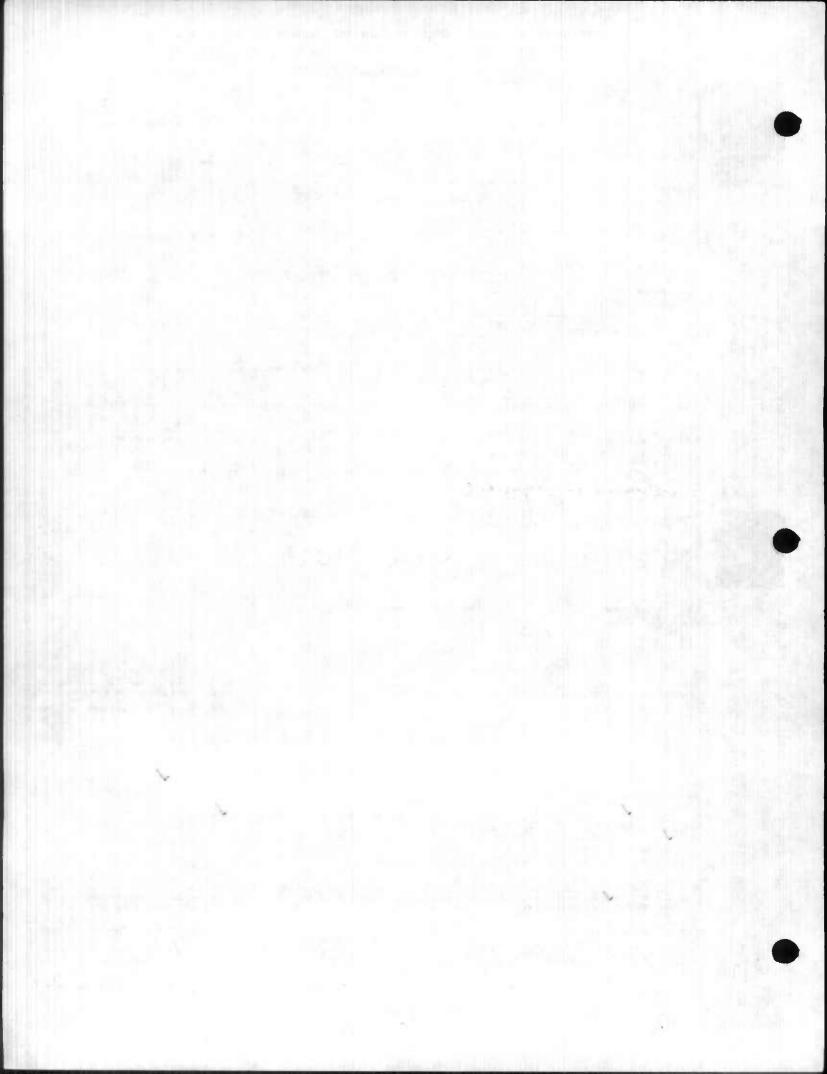
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ian	Martin	~	NVAZ	insl	Ci			Mor	oth Day	5 >	Year	12:08A
cal	4a Facility Nama (If not institutio	n. giva stre	eet and number)	11.10	7		4b. City, Town	, or Location o		County o	f Death	1.0.0011
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DILECTO	Maryland N/A			Balti	more			- n1/				
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2	Frank Mrozinsk			1					Travers	_		
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	Michael Mrozin	ski/E	Brother		6138	Rainbo	w Drive	Elkrid	dge. MD	210)75	
	20a. Mathod of Disposition			20b. Place	of Disposi	ition (Nama o		Data	20c. Lo	ocation - C	City or To	wn, State
	1 Burial 2 XCramation 4 Donation 5 Other (5		noval from Stata					44 40		D 1.		100
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	Edward A.	Step	orchik	-			erick Ro			. MD	213	228
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	shock, or haart tailura. List	t only ona	tions that causad causa on aach lin	tha daath. C						,		Approximata Interval Batween
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State of Maryland / Department of Health and Mental Hygiene 0 0 36055

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 36056

				Ce	Hillical	eon	Death			Reg. No.			
	1. Decedent's Name (First, Mid	dla, Last)							2. Date of Dea	th Day	Year	3. Time	of Death
Physician	Esther Mei	cryman							Month		2000	10.	05
/Medical Examiner	4a Facility Name (If not instituti		d number)		-	-	b. City, Tov	wn, or Loc	cation of Death		y of Death		
Laminer	St. Agnes Hos	spital					Balt.	imore	9	N/A	A		
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs	. last birthday) If Under		If Under 2	24 Hrs.	8. Date of Birt (Month, Da	h Vand	9. Birthpla Countr	ce (State	or Fora
Director	215-70-1083	1□M 2√X	F 70	O Yrs.	Months	Days	Hours		OCT. 9,		Mary	-	
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or 28a-f ahow be notified at Director	10e. Street and Number				10f. Zip	Code				10g. Citizen of	Whet Countr	y?	
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ter death with the Maryland thems 23s or 28s-f show fract naist be notified at -uneral Director	11. Marital Status		Decedent Ever in I	U,S. 13.	Was Dece	dent of H	ispanic Orig	gin? (Spe	cify Yes or No- Ricen, etc.)	14. Ra	ce - America		-
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Mental Merital of Meri	Carl Stigle						Fmma	Roh	inson				
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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 3:160 CARROLL MARSHALL 1 2000 L. /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner STELLA MARIS HOSPICE AT MERCY BALTIMORE If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 17 M 2□F Months Days Hours Min 88 Yrs 212-09-8717 Director Dec. 26 1911 Maryland Usual Residence of Decedent with the Meryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f ahow traumatic event, the Medical Examiner must be notified at Md. n/a Baltimore 1) Yes 2□No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 139 W. Randall Street 21230 USA filed within 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian or Nema Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saitimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify white þ 3 Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Machinist Kopper's Company 5 0 other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Mental Important: If Item 27 is marked or any injury or other traumatic eve DRGS. Pages 1 and 2 should be nent of Health and Mental George W. Marshall Amelia Stecker 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June Doelle (Sister) 118 W. Randall Street, Baltimore, Md. 21230 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Loudon Park Cemetery 11/10/2000 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name end Address of Facility McCully-Polyniak Funeral Home P.A. 23a. Part 1. Enter the disease, or complications that cedsed the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Death **Physician** fmmediate Cause (Finat disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner mane 7 C year The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last and P.O. Box 68760, Due to (or es a consequence of) 4 23b. Did tobacco use contribute to the cause of death? Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 No 3 | Probably 4 | Unknown 2 Division of Vitai Records, Be Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 No certificate or Attending Physician: 25. Was case referred to medice! 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 Natural after death. Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, end due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifie 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier MO 038675

Registrar

State

TOE

31. Date filed (Month, Day, Year)

PAUL

SL

SUITE 605

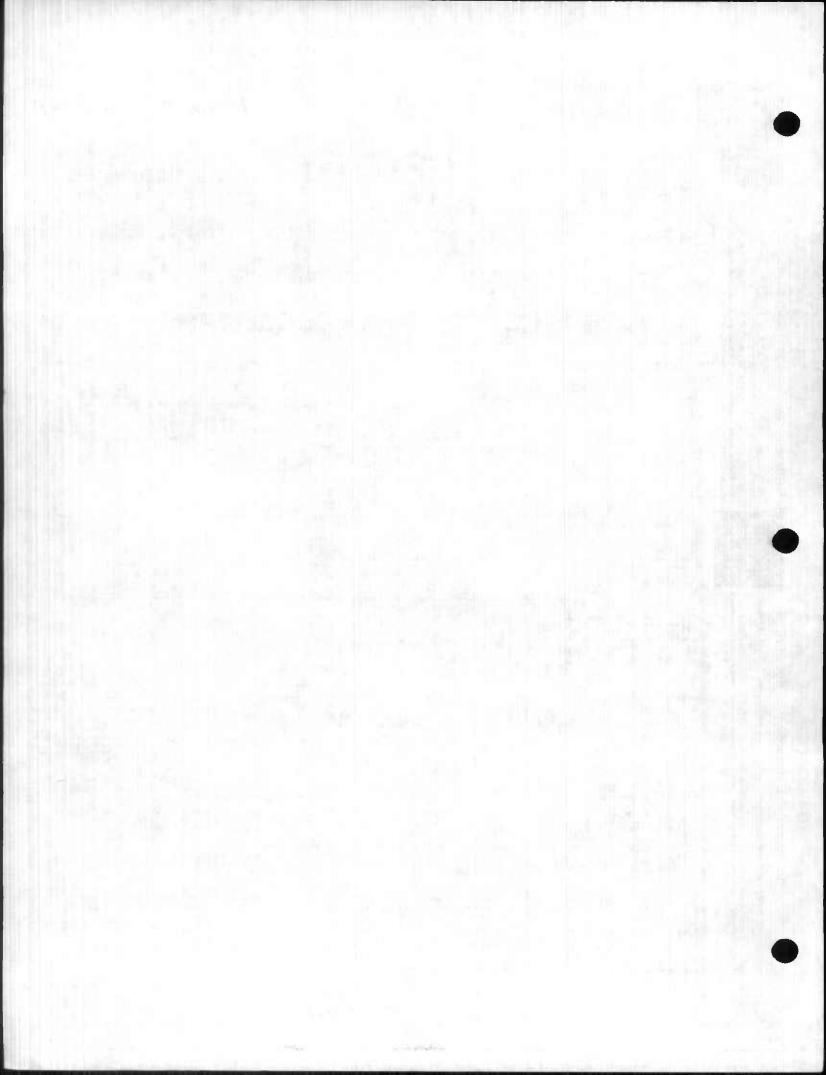
BALTMORE MD 21202

30. Name and address of person who completed ceuse of death (ftem 23a) (Type, Print)

301

32. Registrar's Signature

GT

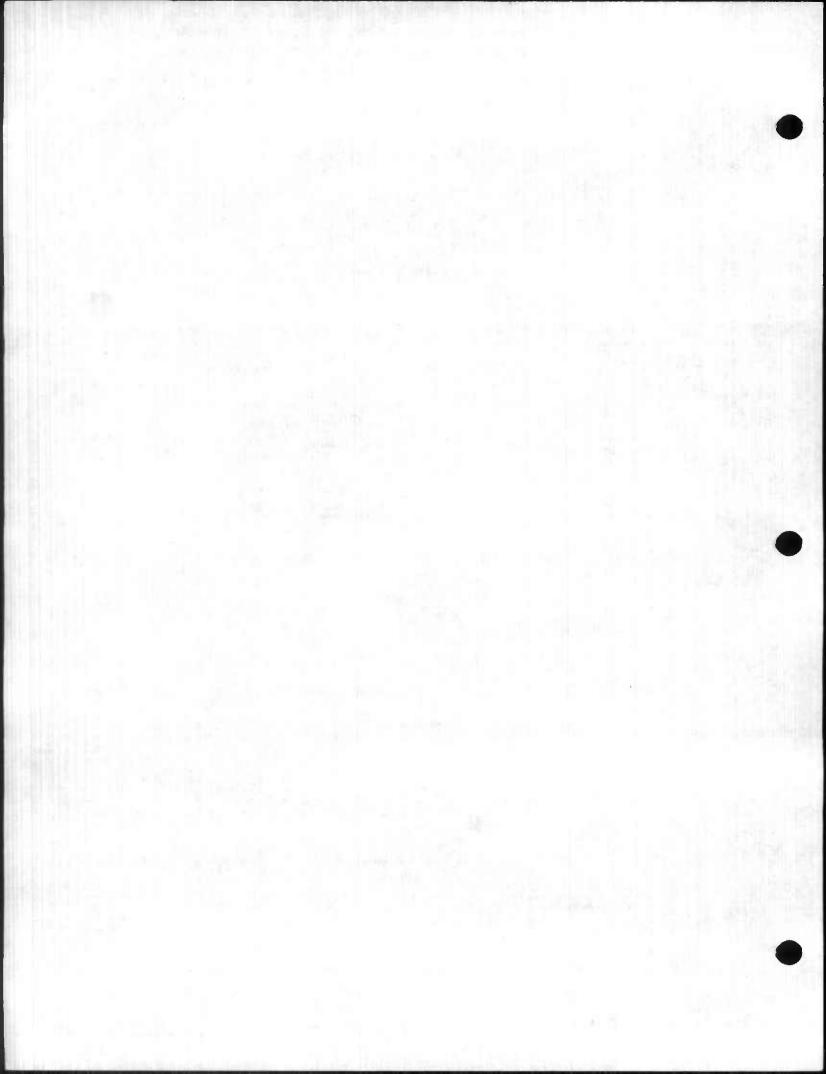


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State of Maryland / Department of Health and Mental Hygiene 00 36058

			Cei	rtificate	of De	eath		Re	g. No.			
	1. Decedent's Name (First, Middle, Las	1)						2. Date of Death Month	Dey	Year	3. Time	of Death
Physician /Medical	HARRY F	R. Mc CAULEY,	JR.					NOVEMBE	R 10 20	000	2:30	0 PM
Examiner	4a Facility Name (If not institution, give MARINER HEALT	street and number) TH OF GLEN BUR	NIE			City, Tow LEN		cation of Death	4c. County		EL C	٥.
Funeral Director	5. Social Security Number 6. Security Number 218–10–0154	9X 7. Age (In yrs. I		If Under 1 Months I		Under 24 Hours	4 Hrs. Min.	8. Dete of Birth (Month, Day, April 1	Year) 8 1919		ace (Stete try) yland	e or Foreign
and show the dist	Usual Residence of Decedent 10a. State 10b. County Md. Anne And	undel Co.	Pasad							10		City Limits
items 23e or 28e-t show ner must be notified at uneral Director	10e. Street and Number 208 Bar Harbor Ro	pad		10f. Zip C		1122		10	og. Citizen of W	/hat Count	USA	
at, or thems 23 Examiner must by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ ▼ Widowed 4 □ Divorced	12. Was Decedent Ever in U, Armed Forces? 1 [XYes 2 □ No if Yes, Give Year or Dates:		Was Deceder	y Cuban, I	anic Origi Mexican, Specify:	in? (Spe Puerto i	cify Yes or No- Rican, etc.)		A - America k, White, c		
"naturn edical	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Decer (Give	dent's Usual (kind of work DO NOT use	Occupation done duni	n ing most o	of worki	ng 1	16b. Kind of Bu	siness/Ind	lustry	
ygiene. He then "natural, to the Medical. Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	Dent		renrea				Self-E	mplo	yed	
Mental Hy srived other atic event To Be (17. Father's Name (First, Middle, Last) Harry R. McCaule	ey, Sr.				Bell		(First, Middle, M Gibso		e)		
W bra diff.	19a. Informant's Name/Relationship (7 Herbert H. Rowe (Route Number, dena, Mo			Code)	
nert of Health int: if Isem 27 iry or other b	20a. Method of Disposition 1 □ Burial 2 ▼Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	laca of Dispo	osition (Neme matory or othe unt Ce	of er place)			Date 2	20c. Location - Baltimo	City or To		
Departm Importar any inju	21. Signature of Funeral Service Lican 23a. Part . Enter the disease, or comp	500			y-Po	lyni	ak E	uneral				
ding physician end se as the bunal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or	r as a consec r as a consec r as a consec	quenca of):								
attence attence of for us	Part II. Other significant conditions or	ontributing to death but not rest	ulting in the u	ınderiying cau	use given	in Part I.		23b. Did to	bacco uss cor	ntributs to	the caus	as of death
een signed by the hould be detache	dementia							1 🗆 Yı	88 2 No	3 Prol	bably 4	Unknor
20 00			24a. Was an autopsy performed?				av	ere autops silable pri mpletion o deeth?				
certificate has b rector, page 2 s								1 □ Ye	s 2 No	10	Yes 2	No
certificate rector, pag	25. Wes case referred to medical axaminer?	Hospital:			Other			(Check only on				
a this ide	1 Yes 2 No 27. Menner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Dey Year)	□ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 □ Residence 6 □ Other (Specify) 28b. Time of Injury at Work? M □ □ Yes 2 □ No			y)						
And the American of American of American of American of the Funeral Director: After the Completely filled in by the funer Medical Certification:	3 Suicide 6 Could not be determined	ome, farm, st	reet, factory,	office			28f. Location (St City or Town	reet and Numb n, State)	er or Rura	il Route N	lumber,	
To the Funeral completely filled		yelcian: To the best of my know niner: On the basis of examinat and manner stated.										ie(s)
To the	29b. Signature and title of certifier		License n		(2)		9d. Date signe					
10 10x	30. Name and address of person who		1 23a) (Type,	Print) 37	20	4 Wil	Ken	s Aven	ne Su	ite 3	203	
	DR. OCHAN 31. Date filed (Month, Dey, Year)	32. Registrar's Signa	ture	Bothin	sece,	no	21:	229				
State	31. Date filed (Month, Dey, Year)	1777 Signa	3	Mi	outh	2)						

ORIGINAL



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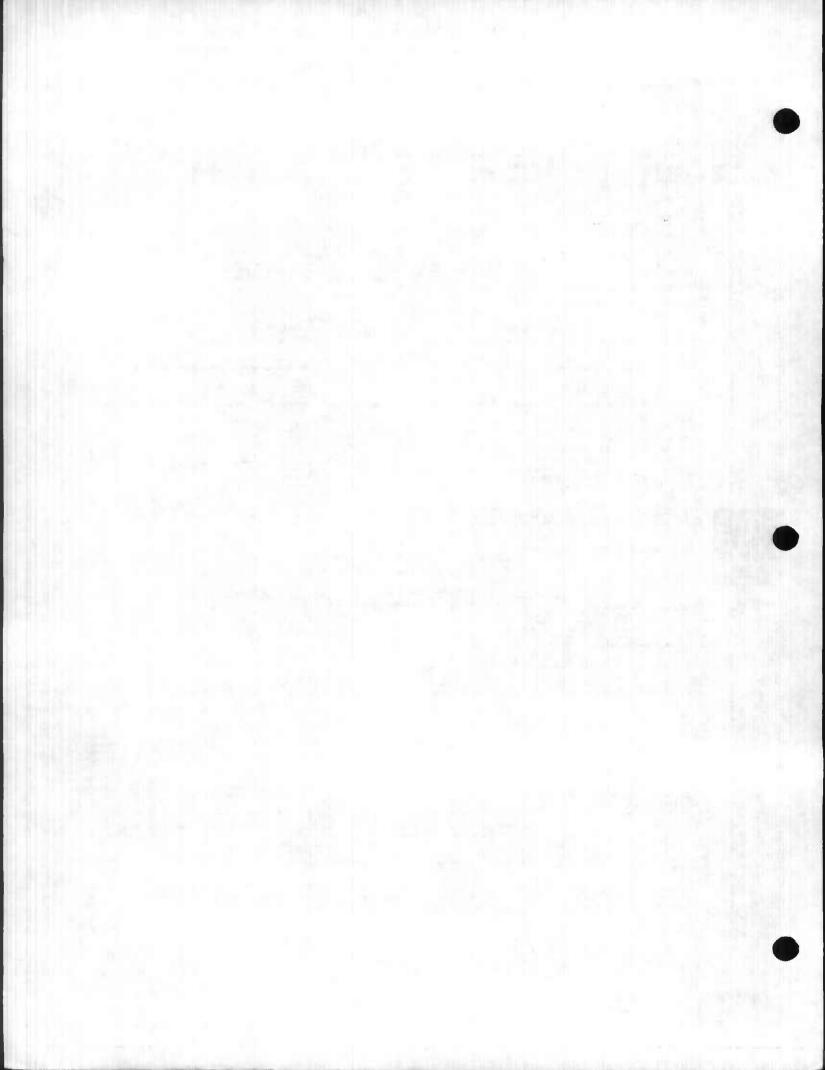
State of Maryland / Department of Health and Mental Hygiene

			Certific	cate of Death	Reg	. No.	36059			
Ohuciaian	1. Decedent's Neme (First, Middle, Last)			2. Date of Death	Day Yes	3. Time of Death			
Physician /Medical		ALVIRDIA	MEADE		NOVEMBE	R 12 20	100 12:17 A			
Examiner	4a Facility Name (If not institution, give			-	Location of Death	4c. County of De	Λ .			
	NORTH ARUN		TAL MILE	Jnder 1 Year If Under 24 Hn	BURNIE	HNNE	HRUNDEL			
Funeral Director	5. Social Security Number 1 6. Se 226-01-7683	0 Age (in yis. 90	Mo	nths Days Hours Mir			Birthplace (State or Foreig Country) IRGINIA			
10	10a. Stete 10b. County	10c. Ci	ty, Town or Location	1			10d. Inside City Limits			
i o	MARKE AND ANDER A	DUNDEL		SEVERN			1 ☐ Yes 2 ☐ No			
rect	MARYLAND ANNE A 10e. Street and Number	KUNDEL _		I. Zip Code	10g	. Citizen of What	Country?			
	7932 TELEGRAPH RO	AD		2114	44	U.S	.A.			
by Funeral Director	11. Meritel Stetus 1 Never Merried 2 Merried 3 🖫 Widowed 4 Divorced	12. Wes Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes:		Decedent of Hispanic Origin? (, specify Cuban, Mexican, Pue es 2☑ No Specify:	Specify Yes or No- rto Rican, etc.)	Black, W	merican Indian, hite, etc. WHITE			
pet pet	15. Decedent's Edu		16a. Decedent's	Usual Occupation	16	b. Kind of Busines	ss/Industry			
r, the Medical	(Specify only highest grad Elementery/Secondery (0-12)	College (1-4or 5+)	life. DO N	of work done during most of w OT use retired)	onking					
omo	6		HOMEMAN	CER		OWN	HOME			
To Be C	17. Father's Neme (First, Middle, Last)			18. Mother's Na	ame (First, Middle, Ma	iden Sumame)				
To T	WILLIAM T	AYLOR N	ASH	JEMI	MA ALVI	ERDA	OSBORNE			
traumatic	19e. Intorment's Neme/Reletionship (T)			dress (Street and Number or F						
other tr		DAUGHTER)		ELEGRAPH ROAD,						
	20e. Method of Disposition 1 XBurial 2 Cremetion 3 F 4 Donetlon 5 Other (Specify)	Removel from Stete	Plece of Disposition cemetery, cremator HAVEN		11/15/2000	c. Location - City 0 LEN BURN				
eny Injury or	21. Signeture of Funeral Service Licens	100-793		ne and Address of Facility S SECOND AVENUE,	INGLETON F					
sician edical miner	Immediate Cause (Final disease or condition resulting in deeth)		a Flnr or esta consequenc	= Shock			2 days			
edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	с	or as a consequenc							
A. A.	resulting in death) Last	d								
detached for use	Part II. Other aignificant conditions co	ntributing to death but not res	sulting in the underh	ring cause given in Part I	23h. Did tohu	cco use contribu	ute to the cause of death			
Physician/M	The state of the s	in source to death out not rea	oning in the uncern	ang cause given an rain.			Probably 4 Unknow			
should be eted by					24a. Was an a performe	autopsy d?	b. Were autopsy findings available prior to completion of cause			
a 0 m						/	of death?			
S C						2 No	1 ☐ Yes 2 ☐ No			
director O Be	25. Was case reterred to medical examiner?	Hospitel:		Other	sath (Check only one)					
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led in by the funera Certification:	3 Suicide 6 Could not be determined	28f. Location (Stree City or Town, S	Location (Street and Number or Rural Route Number, City or Town, State)							
Funeral stely fille dical C	29e. Certifier (Check only one) 29e. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as a control of the cause(s) and the cau									
We work	29b. Signeture and title of certitier 29c. License number 29d. Date signed									
N	Down H		cran	D5364° e Glen Bu	2 N.	0V/2 2	2000			
7/	30. Name and address of person who co	Ol HOSPH		e Elen Bu	rnie M	b 210	61			
State Registrar	NOV 1 4 2000	32. Registrar's Signe	ature de la company							

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State of Maryland / Department of Health and Mental Hygiene 36060

						Death			g. No.		
	1. Decedent'a Nama (First, Midd	die, Last)	.00	1		46		2. Data of Death Month	Dev	Vene	3. Tima of Death
Physician	EUZAB	ETH B.	ME	CNO				Novembe		Year 000	6:30 PM
/Medical Examiner	4a Facility Nama (tf not institution				41	b. City, Tov	vn, or Lo	cation of Death	4c. County		
LAUITITICI	2500 E. Joppe	a Road				Park			Ral-	timor	•
	5. Social Security Number	T T	(tn yrs. last birth	dev) If Unde	r 1 Yaar	If Under 2	4 Hrs.	8. Data of Birth	Dai		elece (State or Fore
uneral irector	212-03-2532	1 M 2 M F 84	1 Yr	rs. Months	Days	Hours	Min.	8. Data of Birth (Month, Dey, 1-9-1	Year)	Coun	MD MD
	Usual Residence of Decedent				1						
B 11	10a. Stata 10b. Count	у	10c. City, Town	or Location			1000			1	Od. Inside City Lim
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be notified Director	10e. Street and Number	INOIC	- 0.2711		p Code			11	og. Citizan of V	What Cour	ntry?
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iners 23s or 23s-f sho liner must be notified at Funeral Director	2500 E. Joppa	12. Was Decedent E	i an in 14 C	42 Mas Dass	212		i-2 (C	all. Van as Na	USA	e - Amaric	an Indian
The Day	11. Marital Stetus	Armed Forces?		If Yas, spe	cify Cubar	n, Mexican,	Puarto I	cify Yes or No- Rican, etc.)		ck, White,	
by F	1 Never Married 2 Ma. 3 Widowed 4 Divorce	If Yes, Give	0	1 Yes	2 No	Specify:			Specify		
					1.0						ite
or than 'netural, the Medical	(Specify only high	nt's Education est grade completed)	16a. L	Decedent's Usu 'Give kind of wo life. DO NOT u	ork done d	ltion lu <i>r</i> ing most	of worki	ng	6b. Kind of Bu	usiness/ini	dustry
13 6	Elementary/Secondary (0-12)		+)						CC: 1	D 4 7 .	14
0 4	8	0	HC	ouse Ke	eping				ffice 1		ungs
Be von	17. Father's Name (First, Middle	, Last)				18. Mother	rs Name	(First, Middle, N	taiden Sumen	ne)	
marked matic s	John Schmidt			10.0		Sus	ie	Johnson			
-	19a. tnforment's Name/Relation	iship (Type, Print)	19b. F	Mailing Addres	s (Street a	and Numbe	r or Rura	l Route Number,	City or Town,	Stete, Zip	Code)
224	Howard Mend/S	Son	25	00 E. J	Joppa	Road	Ba	ltimore	, MD 2	21234	
11.6	20a. Method of Disposition		20b. Plece of D	Disposition (Ne	me ot othar piece	9)		Date	20c. Location -	City or To	own, Steta
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at in the	21. Signature of Forecal Service		Garden	22. Name e				-14-00	Darchik	JLE,	
111	V	7						Funera	1 Home		
	00	2	A	1211 C	hesac	o Ave	nue,	Baltim	ore MD	212	37
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State of Maryland / Department of Health and Mental Hygiene 0 36061

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cician	1. Decedent's Neme (First, Mid	die, Last)					10		2. Date of D Month	eath Dey	Yeer	3. Time of	Death
sician edical	Beatrice L	avalia My	ers						Nov.	9 20	000	1922	
miner	4a Facility Name (If not institut					4			cation of Dee				
	Carroll Cou				1 45 44 4		Westm				rroll		
ral tor	5. Social Security Number 213-16-0547	6. Sex 1 M 2 F	7. Age (In yrs. 78	lest birthdey) Yrs.	Months	Deys	If Under a	Min.	8. Dete of Bi	6, 1922	9. Birthp Coun Tane	vieca (Stete or otry) ytown,	Md.
	Usuel Residence of Decedent 10a, Stete 10b, Coun	tu	100 Ci	ty. Town or Lo	ncation						1	0d. Inside Cit	tu i imite
by Funeral Director		roll		Taneyt								1 Yes	
Directo	10e. Street and Number	IOLL		zanej c	10f. Zij	Code				10g. Citizen of	What Cour	nfry?	
Ö	425 East Balt	imore St.	Apt. 3		2	1787	7			U.S.			
Funeral	11. Meritel Status	12. Was De	ecedent Ever in U	J,S. 13.	Wes Dece	dent of H	ispenic Orig	gin? (Spe	ecity Yes or N		e - Americ		
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5	Wilbur Amos			1		10.			arie Si		04-4- 71-	0.4.1	
	19e. Informant's Name/Reletio			425 E	ast E	alti				Taneyto	vn, M	d. 217	87
	20e. Method of Disposition 1 A Burial 2 Cremetion 4 Donation 5 Other	n 3 Removel fro	m Ctoto	Plece of Dispo cemetery, cre .ontown	metory or	other plea		. No	Dete . 13,	2000 Un:			
-BOUCE	21. Signature of Funerel Service	Eslences		E	ekhar	dt F	ss of Fecilit	1 Ch		er, Md.	2110	2	
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1	shock, or heart failure. Li	st only one cause of									1	Onset end D	
п	fmmediate Cause (Final disease or condition		tro	bahle	£ 5	ept	ric L	1106	er E	DiseAse		19	ceq
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d H												death?	
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1: 70	27. Menner of Death	28a. De	te of Injury	28b. Time of		28c. Injur Wor				how injury occu		197	-
tlor	1 Neturat 5 Pend 2 Accident inves	ding (M stigetion	onth, Dey Year)	Injury	М		k? Yes 2□	No					
Certification:	3 Suicide 6 □ Coul	mined 200. Fie	ece of Injury - At hilding, etc. (Speci	iome, farm, st	reet, fector	y, office			28f. Location City or To	on (Street and Number or Rural Route Number, r Town, State)			
	29a. Certifier (Check only one) 29a Certifying Physician: To the best of my knowledge, deeth occurred at the time, (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opin end menner steted.								d pleca, end due to the cause(s) and menner as stated. th occurred et the time, dete end pleca, and due to the cause(s)			5)	
Me								29c. License number			ed (Month,	Dey, Year)	
	I was	-		رد	2100	0		11/13/2006					
,	20 Name code dd	market committee of											
4	30. Nema and address of person		wase of death (Ite	m 23a) (Type,		570~	ien i	me	NUR	WESTW	ואחפ	2 ma	211

Coroll Journal control control control of the contr

Please Ty

Saint Joseph Medical Center Towson

Yrs.

10c. City, Town or Location

Reisterstown

Teacher

7. Aga (In yrs. last birthday)

74

12. Was Decedent Evar in U,S. Armed Forcas?

1 Yas 2 No If Yas, Giva Yaar or Datas:

Collega (1-4or 5+) 6 1/2 years 10f. Zip Code

21136

1 Yas 2 No Specify:

16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired)

Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Ricen, atc.)

Please Type or Print in Blac						
State of Maryland / I	Department of Health and Me	ental Hygie	ne n	0 3	6062	
	Certificate of Death		. No.	0 0	0002	
1. Decedent's Nama (First, Middle, Last)		2. Data of Death Month	Day	Year	3. Time of De	ath
Elizabeth M. Newman	NO.	OVEMBER	9,	2000	12:06	AM
4a Facility Nama (If not institution, give street and number)	4b. City, Town, or Loc	ation of Death	4c. Cour	nty of Death		

If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year)

12-23-1925

18. Mothar's Nama (First, Middle, Maiden Surnama)

Estelle Starvis

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)

Baltimore

Maryland

14. Race - Amaricen Indian,

Black

Baltimore City Schools

Black, Whita, atc.

10g. Citizen of What Country? USA

16b. Kind of Business/Industry

Birthplaca (Stata or Foreign Country)

10d. Insida City Limits

1 Yas 2 No

/Medical **Examiner**

Physician

213-20-9625

10e. Street and Number

11. Marital Status

10a. Stata

Usual Rasidence of Decedant

21 Berwell Rd.

1 Nevar Marriad 2 Married

3 Widowed 4 □ Divorced

Elamentary/Secondary (0-12)

17. Fathar's Nama (First, Middla, Last)

Ernest Skinner

19a. Informant's Name/Ralationship (Type, Print)

12 th

10b. County

Baltimore

15. Decedant's Education (Specify only highast grada completed)

6. Sex

10 M XXF

Funeral Director

r than "netural", or liente 23a or 28a-f ahow the Medical Examiner must be notified at Director Funeral À Completed permit. Pages 1 and 2 should be file.
Department of Health and Mantal Hy
Important: If New 27 is merised other any Injury or other treumatic event Base.

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

of Vital Records,

Division

Physician /Medical Examiner

use as the burial-trans signed by or Attending Physician: 2 Athaic 9

Physician/Medical P Be Completed Certification: To Medical

a shar death. Hospital 24 hours To the To the To the P

Cheryl-Newman Pope (Daughter) 21 Benwell Rd. Reisterstown, Maryland 21136 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data Burial 2 Cramation 3 Ramoval from Stata
4 Donation 5 Other (Specify) Mt. Zion Cemetery 11-13-00 Landsdowne, Maryland 22. Nama and Addrass of Facility Caple Funeral Services 5502 Winner Ave. Balto., Md. 21215 234 Part. Entar the disaase, of complications that causad the death. Do not entar the mode of dying, such as cerdiac or respiratory arrest, mode, or heart failure. List only one cause on each line. Approximsta Intarval Batween Onsat and Death Immediata Causa (Final disease or condition rasulting in death) UROSEPSIS Dua to (or as a consequence of): Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disaasa or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of) Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ACUTE RENAL FAILURE 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 Yas 2 No 25. Was casa rafarred to medical 26. Placa of Death (Check only ona) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 27. Manner of Death 1 Natural 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Tima of 5 Pending Invastigation 1 Yas 2 No 2 Accidant 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 Could not be datamined 3 ☐ Sulcida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiar 29d. Data signed (Month, Day, Year) 29c. Licansa number 29b. Signatura and titla of certifier D30263 -09-2000

Registrar DHMH 16 Ray 6/95

State

FRANCIS KHOO M.D.

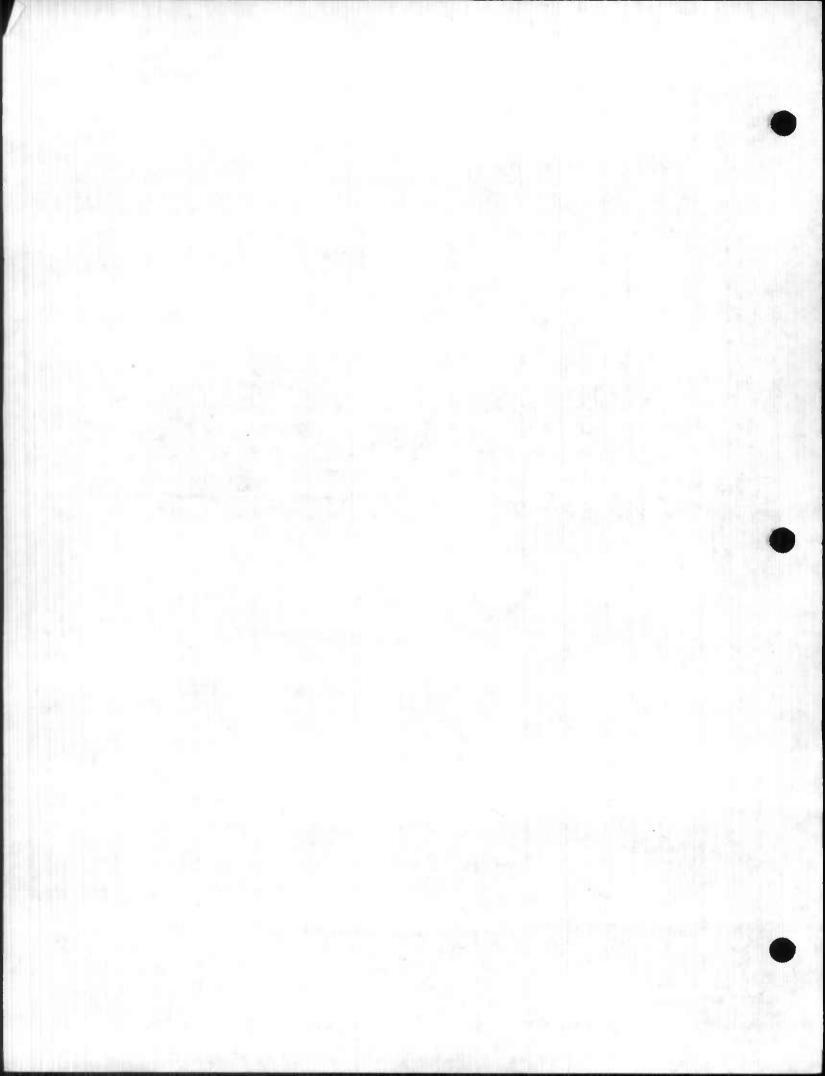
31. Data filed (Month, Day, Year)

30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

32. Ragistrar's Signatura

7601 OSLER DRIVE TOWSON, MARYLAND 21204

ORIGINAL



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

_	Decedent's Nam	e (First, Middle, L	Last)			21.00-y		Death		2. Date	of Death	g. No.		3. Time of Deeth
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Stephwa Joseph Nelson, Sr.

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11/13/1953 Maryland

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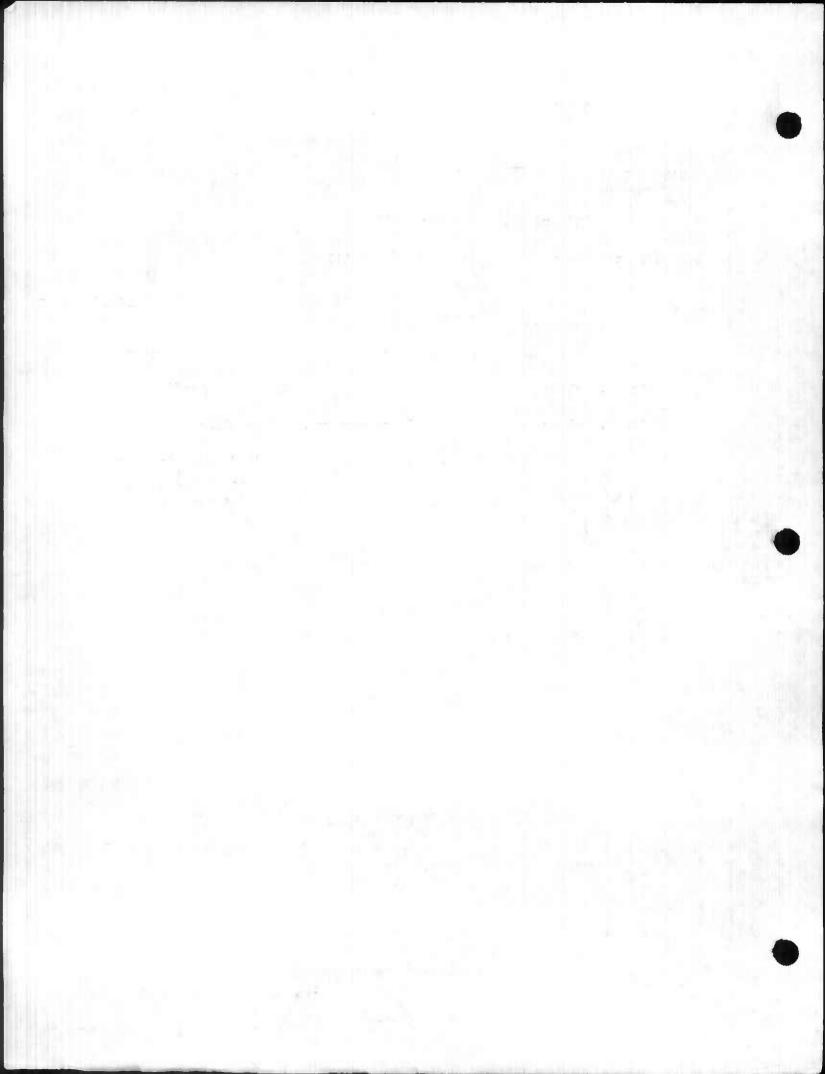
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State of Maryland / Department of Health and Mental Hygiene

Sarah Palmer Certificate of Death Amended Item#14 perFHG789 11/16/2000 EW 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10, SARAH ELLAN PALMER 2000 November 1040 am /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death **Examiner** Shock Trauma Baltimore N/A If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 M 200F Yrs. 18 212-04-7861 MD Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow traumetic event, the Medical Examiner must be notified at 1 Yes 2 No Baltimore Co. Owings Mills Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 2 601 Academy Ave. 21117 USA Funeral aemil. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or flems 23. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 22 No Il Yes, Give Year or Dates: XX Never Married 2 Married Specify: North Maryland 21215-0020 1 Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced American Indian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade com completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Hostess Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Keith A. Palmer Debbra Lynn Anoff 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keith A. Palmer 601 Academy Ave. Owings Mills, MD 21117 Baltimore, 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 Duriel 2 □ Cremetion 3 □ Removal from Stete ö 4 □ Donation 5 □ Other (Specify) 11/13/2000 Reisterstown, MD any Injury Saints Cemetery 22. Name and Address of Facility 11824 Reisterstown Rd Eline Funeral Home Reisterstown, MD or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, ist only one ceuse on each line. 23a, Part1, Ent diseas Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting In death) Last use as the burial-tran Due to (or as a consequence of) The law requires that the death certificate be axed Due to (or as e consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.0. 200 No 3 Probably 4 Unknown signed by 1 Yes Records, Completed by 8 24b. Wera autopsy findings available prior to completion of ceuse of death? 24a. Wes an eutopsy performed? certificate has page Yes 2□ No Yas 2 No of Vitai or Attending Physician: funeral director, 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 No XXInpatient 2 ER/Outpatient 3 DOA After this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 03 YO Division 5 Pending 1 Natural to accide М death. investigation 1 Yes sperger 100 -1) Director: A 22 Accident 10 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Toym, State) 28e Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide R Jeminery To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**CMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stelled. 29a. Certifier completely 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 11, 2000 and address of person who completed cause of death (Item 23a) (Type, Print) ARON LOCKE 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) NOV 1 4 2000 32. Registrar's Signature State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36065 Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth NOVEMBER 9, Zeer OO MARIAM OKOPOVA 7:49 Am 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthdey) If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer) mar. 2, 1913 Birthplace (State or Foreign Country) Months Days 217-35-6733 1 ☐ M 20% F Hours 87 UKRAINE Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A BALTIMORE 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3615 FORDS LANE #213 21215 U.S.A. 12. Wes Decadent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 t. Maritel Stalus 14. Race - American Indien Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 Yes 2 No Specify: WHITE 3 Widowed 4 □ Divorced Yeer or Detes: 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) ELEYA LERNER RAZIEL SHATZ 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) LINA KALANTYRSKAYA / DAUGHTER 6960 BROOKMILL ROAD #2-D, BALTIMORE, MD 21215 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 M Burial 2 ☐ Cremetion 3 ☐ Removel from State 11/10/00 BALTIMORE, MD arlington chizuk amuno 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or it is a feiture. List only one cause on each line. Approximate Intervel Between Onsel end Death Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Due to (or es e consequence of) Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown Ve her dialion 1 Yes 2 No 24b. Were autopsy findings aveileble prior to 24e. Wes en autopsy performed' completion of cause of death? 1 Yes 2 N 1 ☐ Yes 2 ☐ No

Physician /Medical **Examiner**

Physician

/Medical

Examiner

MD

Funeral

Director

ral', or iteme 23a or 28a-f show Examiner must be notified at

other than "natural",

permit. Pages 1 and 2 should be fit.
Department of Haatth and Mental Hy
Important: If Itam 27 is merked other
any Injury or other traumetic event

the Medical.

Director

Funeral

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Completed

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the Maryland

death or items

Baltimore, Maryland 21215-0020

physician and s the burial-transit certificata be executed signed by t d be detach certificate this After

Box 68760,

P.O. 1

Physician/Medical Examiner þ Completed Be Medicai Certification: To

27. Menner of Death

Records, Division of Vital the Hospital or Attending Physician: nin 24 hours after death. Director: / To the Hospital
within 24 hours a
To the Funeral C
completaly filled

State Registrar 29b. Signature and title of o hetitim: 4 30. Name and address of pr

5 Pending investigation

6 Could not be

MI

28e. Dete of Injury (Month, Dey Year)

1 Inpatient 2 □ ER/Outpatient 3 □ DOA

Plece of Injury - At home, farm, street, fectory, offica building, etc. (Specify)

28b. Time of

29c. License number

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner as steted.

2 More cal Examiner: On the best of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner stated. 29d. Date signed (Month, Day, Year) Nonember 9,2000

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

conspleted cause of deeth (Item 23a) (Type, Print) -, Jr. IMPERIAL

2000

26. Piece of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 8 Other (Specify)

28d. Describe how injury occurred

31. Date filed (Month, Day, Year) NOV

25. Wes case referred to medical

1 Yes 2 No

1 Natural

2 Accident

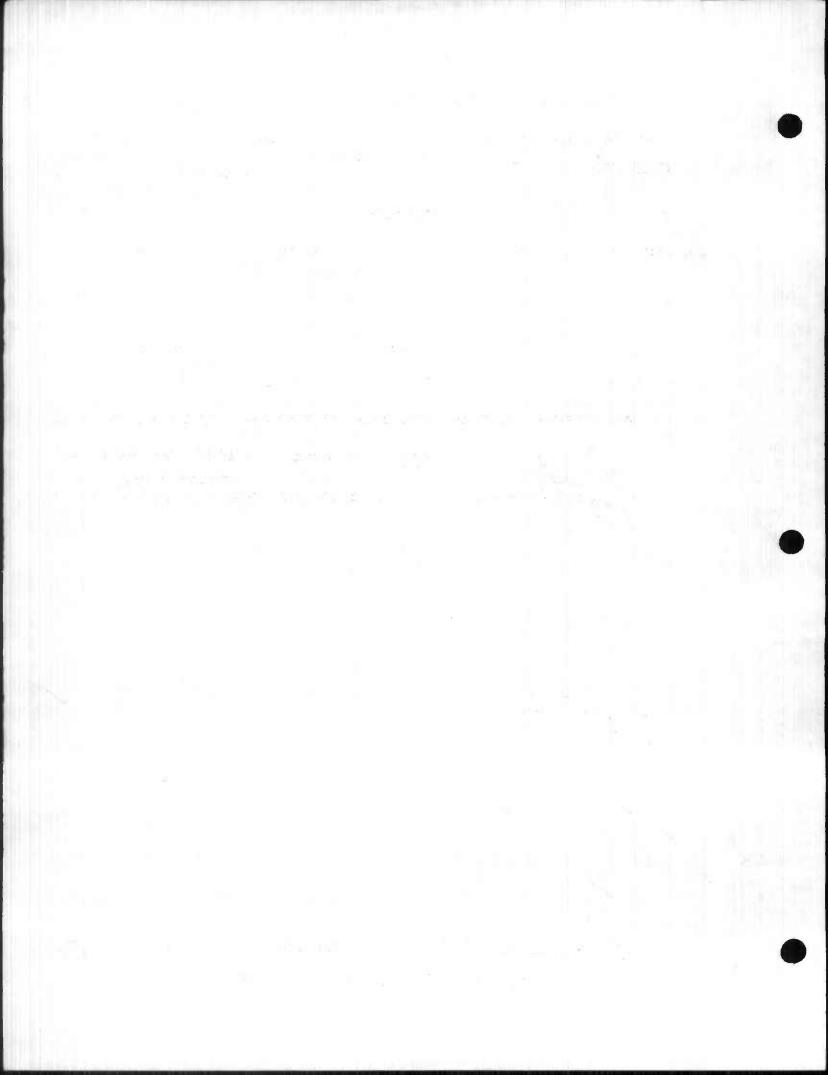
3 Suicide

29e. Certifier (Check only

4 ☐ Homicide



DHMH 16 Rev 6/95

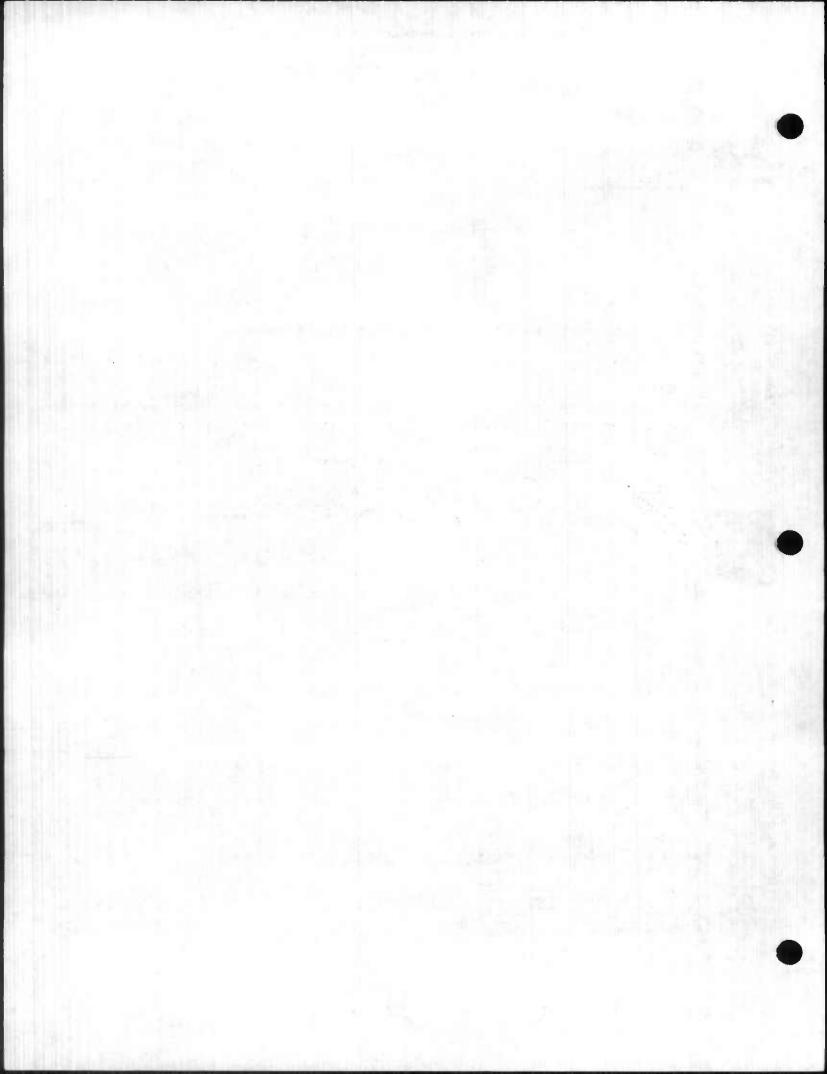


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19b. Informent's Name/Relationship (Type, Print) James Porter JrHusband 850 Glenwood Ave, Baltimore Md 21212 20b. Member of Bioperillo ROBerial 2 Clorenation 3 Deneroval from State 4 Donation 5 Clorke (Specific) ROBerial 2 Clorenation 3 Deneroval from State 4 Donation 5 Clorke (Specific) 20b. Name and Address of Facility March F/H West 4300 Wabbash Ave. Baltimore Md 5 Requentially list conditions 8 Republish (Specific) 1 Republish (Specific) 1 Republish (Specific) 1 Republish (Specific) 2 Republish (Specific) 3 Republish (Specific) 4 Republish (Specific) 5 Republish (Specific) 5 Republish (Specific) 5 Republish (Specific) 5 Republish (Specific) 6 Republish (Specific) 6 Republish (Specific) 6 Republish (Specific) 7 Republish (Specific) 8 Republish (Specific)												ne)
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22. Name and Address of Poorts 23. Name and Address of Poorts 24. Name and Address of Poorts 24. Name and Address of Poorts 25. Name and Address of Poorts 26. Page 1. Service Control of Poorts 26. Page 26.					□ Removal from				ece)	Dete	20c. Location	- City or Town, State
22. Name and Address of Facility March F/H West 4300 Nabash Ave. Baltimore Md 21215 Approximate failure. List only one cause and search of death. Do not enter the mode of dying, such as cardiec or respiratory arrest. Immediate Cause (Final institution of the cause of the death. Do not enter the mode of dying, such as cardiec or respiratory arrest.							arriso	n Fores	t Vet.	11/13	/00 OW:	ings Mills
24a. Was an autopsy performed? 24b. Were autopsy fine available prior to completion of cau of death? 1 Yes 2 No 1 Y			in quatry	à!	10-7	Due to	o (or as a cons	equence of): FIBR	OSIS C	ey F	E LUI	~6 784 ~6 16 40
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29e. Certifier (Check only one) 29e. Certifier (Check only one) 29e. Signature of the detail Examiner: On the best of my knowledge, death occurred at the time, detained and place, and due to the cause(s) and manner as stated. 29e. Signature of the detail Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, detailed and place, and due to the cause(s) and manner as stated. 29e. License number 29d. Date signed (Month, Dey, Year) 29d. Date signed (Month, Dey, Year) 29d. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29d. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29d. Date signed (Month, Dey, Year)	To Be Completed by Physician/Medical	Part II. Of	ially list condition in the condition of	nt conditions	da contributing to	Due to	o (or as a consection of conse	equence of): underlying cause gi	iven in Part I. 26. Place of Dether: 4 □ Nursing	23b. Dic 1 = 24a. Wa per 1 = eath (Check only	d tobacco usa college an autopsy iormed? Yes 2 A No one)	pontributa to the cause of d 3 Probably 4 Uni 24b. Were autopsy find aveilable prior to completion of caus of death? 1 Yas 2 No
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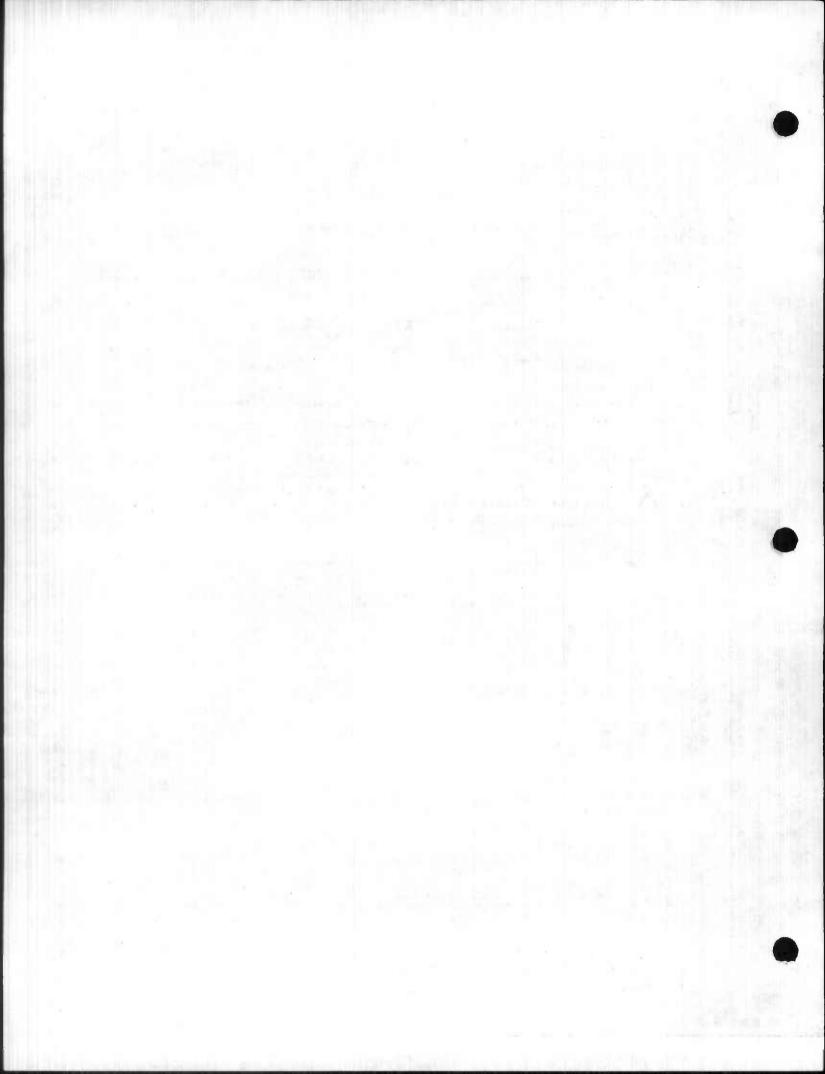
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			Certificate o	f Death	Reg. No.	00 30007		
Physician	1. Decedent's Name (First, Middle, L		C - D-1	2.	Date of Death Month Day	3. Tima of Death		
/Medical		Paulette	C Petr		NOVEMBEN 1	13 2000 318A		
Examiner	4a Fecility Name (If not institution, gr			4b. City, Town, or Locat	tion of Death 4c.	County of Death		
	Upper Chesapea	ke Medical Cent	ter	Belair		HArford		
1		Sex 7. Age (In yrs.	Months Day	ar If Under 24 Hrs. 8. ys Hours Min.	Date of Birth (Month, Day, Year) uly 27 194	Birthplace (State or Foreign Country)		
or	216-52-4450 Usual Residence of Decedent	1U M 3/QX* 50) 113.	U	uly 27 194	19 Maryland		
	10a. State 10b. County	10c. Cit	y, Town or Location			10d. Inside City Limit		
5	MD HAr	ford		Edgewood		1□Yas 2√DN		
Director	10e. Street and Number		10f. Zip Code		100 C#	zen of What Country?		
ă	912 Topview	Dwisso						
runeral		12. Was Decedent Ever in U		21040		JSA 14. Race - American Indian.		
	11. Merital Status	Armed Forces?	If Yes, specify C	of Hispanic Origin? (Specif uban, Mexican, Puerto Ric	an, etc.)	Black, White, etc.		
	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No W Yes, Give Year or Dates:	1□Yes 2₩N	lo Specify:	DE	Specify: White		
	15. Decedent's 8		16a. Decedent's Usuat Occ		16h Mi			
3000	(Specify only highest gi	rade completed)	(Give kind of work do	ne during most of working ired)	16b. Kind of Business/Industry			
	Elementary/Secondary (0-12)	College (1-4or 5+)	Homemaker	-00)	own home			
	12th 17. Father's Name (First, Middle, Las	1)		18. Mother's Name (F				
	PAul Poling	,				ounany,		
			1		ae ESdah			
	19a. Informant's Name/Ralationship		19b. Mailing Address (Stre					
	John J. Petr 11		912 Topview Mace of Disposition (Name of		ewood MD	21040		
	1 Burial 2 Cremation 3	Removal from Stata	emetery, crematory or other p	olace)		cation - City or Town, State		
	4 Donation 5 Other (Spec	ify) Me	eadowridge Cem	netery 11/15/	/2000 Ba	11timore MD		
	21. Signature of Funeral Service Lice	INS66	22. Name and Add					
	1 Tibas	16 - 14	Conn	elly Funeral	L Home of	Essex		
	23a. Part1. Enter the disease, or co shock, or heart failure. List no	plications that caused the deat	Do not enter the mode of o	MACE AVE Bailing, such as cardiac or re	eltimore Mespiratory errast,	10 • 21221 Approximate		
	Shock, or heart failure. List on	one cause on each sine.	1			Interval Between Onset end Deeth		
	Immediata Causa (Final	1. LI						
	diseasa or condition resulting in death)	a. HLRYThm	TIA					
		Oue to (c	7 A pras a consequence of):	,	11-			
K-ABILLING		b. CHRONIC	8 DITAUCTIV	& PULMONAN	y OliSEA	56		
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	Cause (Disease or Injury that initiated events	C						
	resulting in death) Last	Due to (o	r as e consequence of):			t I		
Physician/M		d.						
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nandillion.					24a. Was an autop performed?	24b. Wera autopsy findings available prior to completion of cause		
					1.7	of death?		
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	25. Was case referred to medical			26. Place of Death (C	Check only one)			
	examiner? 1 ☐ Yes 2 ☐ No	Hospitat: 1 Inpatient 2	ER/Outpetient 3 DOA	Other	5 ☐ Residence 6	6 Other (Specify)		
0 10	27. Manner of Death	28e. Data of Injury (Month, Day Year)	28b. Time of 28c. In		d. Describe how injury			
Certification:	1 Naturat 5 Pending 2 Accident investigation			Yes 2 No				
IIICI	3 ☐ Suicide 6 ☐ Could not I	289. Place of injury - At no	ome, farm, street, factory, offic	281	Location (Street and	d Number or Rural Route Number,		
	4 Homicide	building, etc. (Specif		City or Town, State))			
Dallea	(Check only 2 Medical Exa	miner: On the basis of examinal and manner stated.	tion and/or investigation, in m	y opinion, death occurred	at the time, date and	place, and due to the cause(s)		
Me	29b. Signature and title of certifier	und illusion statou.	29c 1 inc	ense number	29d Date	e signed (Month, Day, Year)		
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	Lyaman	4076	1) -	1220	//	2/014-4324		
	30. Name and eddress of person who		23a) (Type, Print)	2 1	n. m 1	,		
	F. YAMAMIT	500 UPRE	ChESAREAKE VI	LIVE DE/ K	tin 1110	2/014-4324		
•	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture					
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00-6431-510 crn Patricia A. Perkins

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene []

36068

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3 Time of Death Month **Physician** 1305 PATRICIA PERKINS /Medical 4b. City. Town, or Location of Deeth 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE 5 HOCK TRAUMA HOSPITAL If Under 1 Yeer 5. Social Securify Number 7. Aga (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (Stata or Foraign Country) **Funeral** Months Days Hours 1 M 2 X F Yrs Director 217-72-6171 44 Maryland Usuat Rasidence of Decedent 10c. City, Town or Location 10a. Stata 10b. County 10d. Insida City Limits 1 ☐ Yas 🏖 ☐ No Directo Maryland Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a or 3 21144 7885 Telegraph Road Funeral USA 12. Wes Decedent Ever in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yes or No ff Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Merital Stetus 1 Yas 2 No if Yas, Giva Yaer or Datas: 1 Nevar Married 2 Merried 8 Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: 3 Widowed 4 Divorced White 16a. Decedant's Usuel Occupation (Give kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Cottege (1-4or 5+) 12 N/A Disabled N/A 17. Fether's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) Pages 1 and 2 should be nent of Health and Mental ant: If Nem 27 is marked o Charles Henry Wassell Virginia Louise Dockery (pure) 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Gregory Lee Wolfe/Son 7885 Telegraph Road Severn, MD 21144 20a. Mathod of Disposition
1 ☐ Buriai 2 ☐ Crametion 3 ☐ Removal from State 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Metro Crematory Inc. 11-13-00 22. Name end Addrass of Fecility Cremation Society of MD, Inc. Edward A. 299 Frederick Road Baltimore, MD regorchik 21228 23a. Part1. Enter the disease or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or haert failure. List only one cause on each line. Approximate Intervei Between Onsat and Death Physician Immediate Causa (Final disaasa or condition rasulting in death) /Medical Dulmonan Examiner Examir Sequantielly list conditions, if any, laading to immadiata cause. Enter Undartying Cause (Disassa or injury that initiated avents rasulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Physician/Medical Dua to (or as a consequence of) Box P.O. Part ff. Other significant conditions contributing to death but not rasulting in tha undarlying causa givan in Part f. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à of Vital Records, 24b. Ware autopsy findings eveilabla prior to complation of cause of death? 24a. Was en autopsy performed? Be Completed 1 Yas 2 No 1 Yas 25. Was casa rafarrad to medical 26. Placa of Death (Check only ona) axaminar? 1 Yas 2 No Hospitat: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 10 ä 28d. Dascribe how injury occurred 27. Mannar of Death 28b. Tima of edical Certification: or Attending F after death. Director: After Division □ Natural 5 Panding 18 53 PM 2 Accidant invastigation pedestran 11-3-00 ped 8 Struck Ly car

281. Location (Street and Number or Rural Route Number,
City or Town, State) Telegraph and Annapolis Struck 6 Could not be datarmined 28a. Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify) 4 Homicide 5-reet Roads, Odenton, Maryland /To the Hospital
within 24 hours
To the Funeral Completely filled Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and dua to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of axaminetion and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier 29d. Data signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. Licansa number mccunn 30. Name and addrass of person who complated causa of death (Item 23a) (Type, Print) 22 South Greene Street, Baltimore, Maryland 21201 MCCUUN 31. Dete filed (Month, Day, Year) #32. Registrer's Signatur State

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Registrar

NOV 1 4 2000

Strategies senting

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2 Date of Death 3. Time of Death 3:35 AM Charles Edward Rodenhi 2000 NOY 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death St. Agnes Hospital Baltimore
| HUnder 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 6. Sex 1 ⋈ M 2 ☐ F If Under 1 Year Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) Deys Hours Min Yrs 83 MAY 19, 213-10-6720 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 314 Lee Drive 21228 12. Wes Decedent Ever in U,S. Armed Forces? 1 M Yes 2 □ No 1944-It Yes, Give Year or Detes: 1946 14. Rece - American Indian, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Never Merried 2 ☐ Merried Specify 3 Widowed 4 Divorced 1946 White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Salesman Retail 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) James Edward Rodenhi Mary Reimer 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Elizabeth J. Rodenhi/Wife 314 Lee Drive Catonsville, MD 21228 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stata 20e. Method of Disposition Dete 1 ☐ Buriel 2 【Cremetion 3 ☐ Removel from Stete 11-11-00 Baltimore, MD Metro Crematory Inc. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility
Cremation Society of MD, Inc. orchik 299 Frederick Road Baltimore, 21228 Approximete Intervel Batween Onset and Deeth 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Physician /Medical Examiner

Physician/Medical Examir

Physician

/Medical

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10a. Stete

Maryland

Funeral

Director

or items 23a or 28a-f show

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al Hygiene.

Pages 1 and 2 should be nent of Health and Mental int: If item 27 is marked o

permit. Pages 1 and 2: Department of Health as Important: If Item 27 is eny Injury or other trauping.

the Medical Examiner must be notified at

Director

Funeral

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Completed

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filed within 72 hours after death

Maryland 21215-0020

Baltimore,

68760.

Box

Division of Vital Records,

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To the Hospital of Within 24 hours a To the Fureral D checkens tilled

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Certification:

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Sequentielly list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events that Initiated events resulting in death) Lest

Immediate Cause (Finel disease or condition resulting in deeth)

Week Pheumoni Due to (or es e consequença of) Due to (or es a consequenca of): Due to (or es a consequença of)

Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert II.

23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No

24a. Wes an autopsy performed?

24b. Were autopsy tindings available prior to completion of cause of death?

1 🗆 Yes 2 No

ACNES HOSPITAL BLT MD

1 Yes 20 No

25. Wes case referred to medical 1 Yes 2 No 27. Menner of Death Neturet Accident

5 Panding investigation 6 Could not be determined

Hospitet: 1 inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 Nursing Home 5 Residence 8 Other (Specify) Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

26. Place of Death (Check only one)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end pieca, and due to the cause(s) and menner stated.

29b. Signefure and title of certifier

29d. Dete signed (Month, Day, Year)

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) KAN KON DE MUTOMBO

31. Date filed (Month, Day, Year)

NOV 1 4 2000

32. Registrer's Signeture

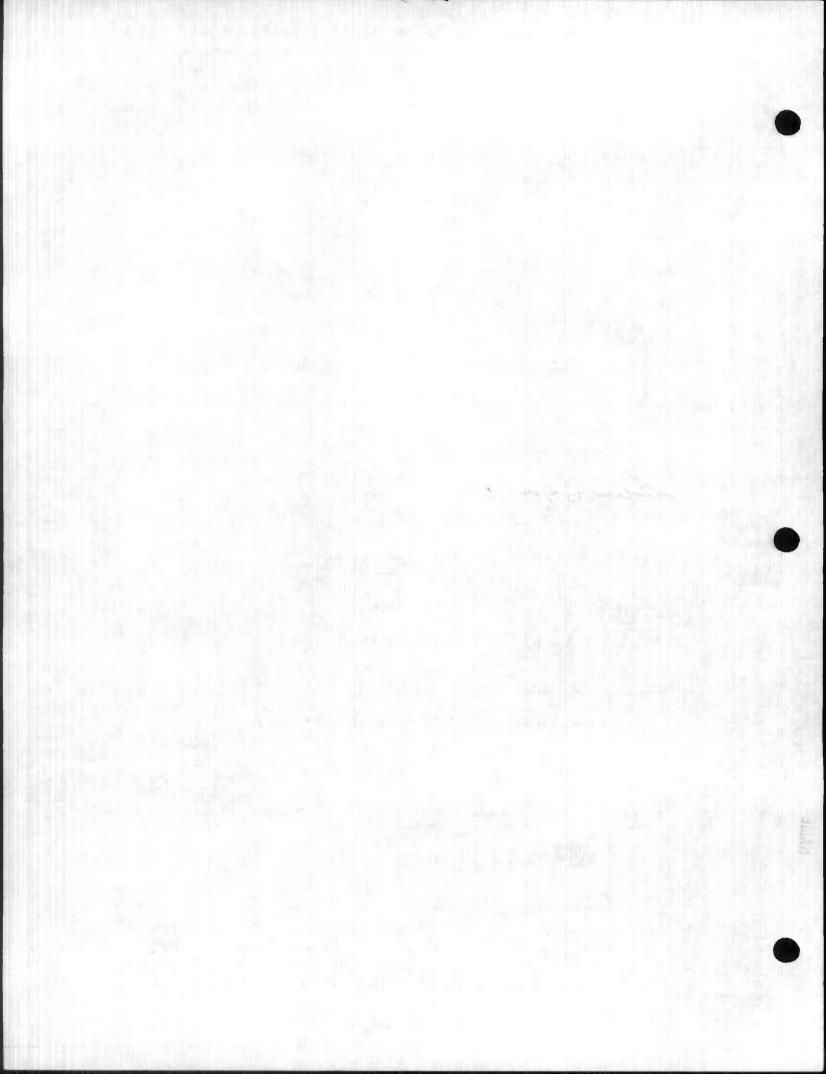
28e. Placa of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

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DHMH 16 Rev 6/95

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item 5,7,8 per fh G789 11/14/00 yf Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3 Time of Death Month Year **Physician** A.N 2000 /Medical 4b, City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 3 A al If Under 24 Hrs. If Under 1 Year 6. 56 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 8. Date of Birth 10/5/34 (Month, Day, Year) **Funeral** Days Hours 1 M 2□ F 5 66 Yrs. Director Usual Residence of Decedent with the Maryland 10a. Slate 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f ahow the Medical Examiner must be notified at ALTO Ves 2□No Funeral Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? WAL 1206 U.S 1 Merital Stelus 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Maxicen, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0020 1□ Yes 2No λq 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry JLA9 then Elamantary/Secondary (0-12) College (1-4or 5+) Md 2 M Abore 7 is marked other traumatic event, is permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Nem 27 is marked oth any Injury or other traumatic event and Injury or other traumatic event and Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) BROOKS 03/8 110 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19e. Informant's Name/Ralationship (Type, Print) 20b. Place of Disposition (Name of cemetary, crematory or other place) BdeTa 10 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) EM 22. Name and Address of Fecility 21. Signature of Funeral Service Licenses Approximate interval Between Onsel and Death Part1 Enter the disease, or complications that ceused the snock, or haart failure. List only one causa on aach line. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** /Medical Immediele Causa (Final diseasa or condition resulting in death) Examiner Due to (or as a Physician/Medical Examiner tate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Sequentially list conditions, if any, laading to immadiate causa. Enter Underlying Cause (Disease or injury that inhitated evants rasulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy Be Completed this certificate has 2 No 1 ☐ Yes 1 ☐ Yes 2 No 25. Was casa rafarrad to medicel 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) edicai Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 27. Manger of Death 28b. Time of

or Attending Physician: The law requires that the death certificate be assecuted Box 68760, Division of Vitai Records, P.O. After death.

within 24 hours after death To the Funeral Directors, completely filled in by the To the

28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 3 Suicide 6 Could not be 4 I Homicida Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature 29d. Date signed (Month, Day, Year) 29c. License number M.D.

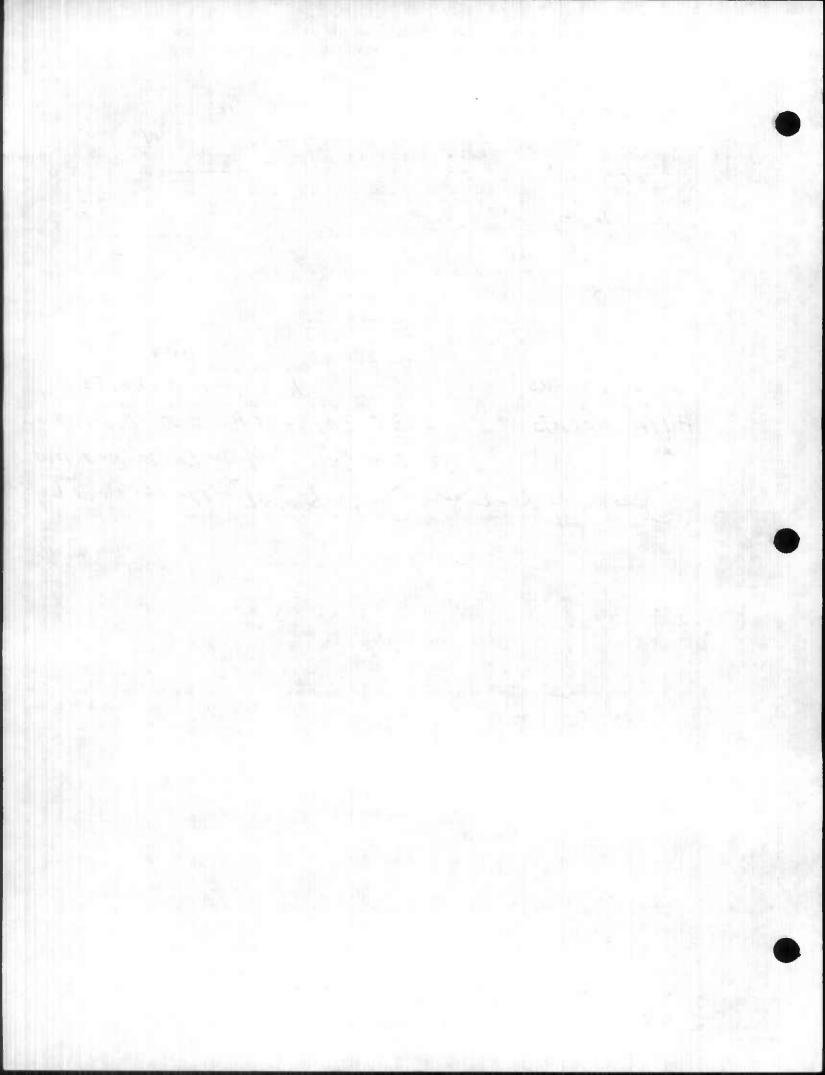
State Registrar 31. Date filed (Month, Day, Year)

4940 ch 32. Registrar's Signature

n who complated cause of death (Item 23a) (Type, Print)

EASTERN AVE. A BuildINGRM#112 BAHIMMEMD

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State of Maryland / Department of Health and Mental Hygiene

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## County of Death County of		Earl A	nderson :	Rosenbe	rger									9:3	5 AM
Social Security Number S. Sec		4a Facility Neme (If not institution, gi	ve street and n	iumber)				4b. City, To	wn, or Loc	ation of Death	4c. County	y of Death		
12		VA MARYI			SYSTEM	1	90.0					CEC	CIL		
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19e. Informent's Name/Felationship (Type, Print) 19e. Malling Address (Street and Number or Flural Route Number, City or Town, State, Zip Code) 541 Main St. Reisterstown, Md. 21136 200. Date of Chippership (State Number) 200. Place of Disposition (Nume of Lance) 200. Place	0 10	Samuel	Rosenbe	rger											
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	1	Doorgoo 1 Novimber 1							K TZ,	2000)				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAMIR KHEIRI, M.D., VA MARYLAND HEALTHCARE SYSTEM, PERRY POINT, MD 21902	101														

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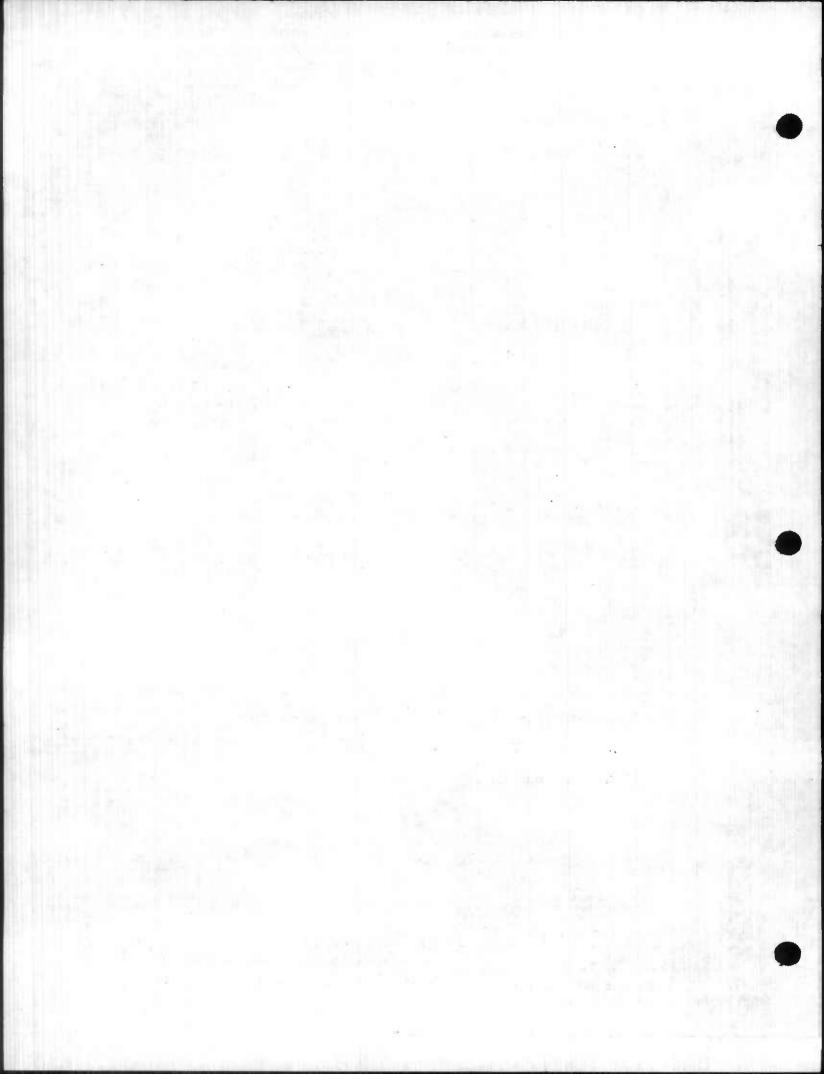
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п	Physician /Medical Examiner Funeral Director Purple of physical processors of physical physical processors of physical	Decedent's Name (First, Middle, Last) HANS RICHTER							2. Date of D Month	Day	Year	3. Time of Death	
		4a Facility Name (If not Institution, giva street end number)						4h Cihr Town	or Location of Dea			4:30 PM	
			VT NURSIN					EASTPO			IMORI		
-		5. Social Security No		7. Age (In yrs. last birthdey) If Undar 1			r If Undar 24		irth 9. Birthplaca (Stete or Country)				
L		212-01-516 Usual Residence of	0/	1⊠M 2□F 86		Yrs.	Months Days	Hours Min. (Month		-14		MD	
		10a. State 10b. County 10c. City, Town or Location							10d. Inside City Limits 1 ☐ Yes 2 ☑ No				
		MD 10e, Street and Num	BALTIN	ORE	ORE ROSEDALE					10g. Citizen of V	Albert Cour		
				DOAD				227				My 7	
	her death r Herre 23s siner mast	8012 SAC	GRAMORE I	12. Was Dece	dent Evar in U,	S. 13. V		237 Hispanic Origin	? (Specify Yas or N		USA 14. Raca - American Indian,		
980	or N. o	1 Never Marrie		If Yes Give			Yes, specify Cu ☐ Yes 258 No	Hispanic Origin? (Specify Yas or No- ban, Maxican, Puerto Rican, etc.) Specify:		1 100	Bleck, Whita, etc. Specify: WHITE		
9		/Cneci	15. Decedent's Edity only highest gre	lucation	cation 168		6a. Decedent's Usual Occupation (Give kind of work done during most of work)			16b. Kind of Business/Inde			
2121	ed within 72 ho ygiene, we then "neturn 4, the Medical II Completed	Elementary/Secon	Elementary/Secondery (0-12) College (1-4o			life. DO NOT use re			etired)		BARREL MAKING		
D	tal Hyg d other event, Be C	17. Father's Name (17. Father's Name (First, Middle, Last)					18. Mother's	Name (First, Middle	dle, Maiden Sumeme)			
Maryland 21215-0036	Menta Menta arkad artic so To B	JULIUS H	RICHTER					MARY	LEIMKUH	LER			
	and N	t9a. Informant's Na	me/Relationship (Type, Print)		19b. Mailin	ng Address (Stree	et end Number o	r Rural Route Num.	ber, City or Town,	Stete, Zip	Code)	
	and	EDNA (GARBER/SI	STER			SAGRAMO	RE ROAD		RE MD 21			
ore	r offine or offi	20a. Method of Disp	osition Cremation 3 D	Ramoval from 5	C	lace of Dispo ametery, cren	sition (Neme of netory or other pl	ece)	Date	20c. Location	City or To	own, State	
Ë	Pag ment:		5 ☐ Other (Specif				AKLAWN CEMETERY 1			13-00 BALTIMORE, MD			
Baltimore,	Depart Import any in	21. Signature of Formal Second Location 22. Nama and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE ROSEDALE, MD 21237											
-		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failura. List only one cause on each line. Approximate Interval Between											
	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Due to (of as a consequence of): Onset and Death J 147											
Box 68760,	death certificats be executed a strending physician and id for use as the buttal-transit sician/Medical Examiner	Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of):											
	death e atte ed for	Part II. Other algnific	cant conditions o	ontributing to de	ath but not rasu	ulting in the u	nderlying cause g	ivan in Part I.	23b. Dle	d tobacco use co	ntribute t	to the cause of death?	
P.0	ulres that the deal signed by the at id be detached to de by Physician by Physician burners and by Physician burners and by Physician burners are also be a burners and burners are a burners are a burners and burners are a burners are a burners and burners are a burners are a burners are a burners are a burners and burners are a burners are a burners are a burners are a burners and burners are a burners are a burners and burners are a burners are a burners are a burners and burners are a burners are a burners and burners are a burners are a burners and burners are a burners and burners are a burners and burners are a burners are a burners and burners are a burners are a burners and burners are a burners are a burners and burners are a burners are a burners and burners are a burners are a burners and burners are a burners are a burners and	Part II. Other algorificant conditions contributing to death but not rasulting in the underlying cause given in Part I. After sclertic Heart Disease with Colon following							10 10	1 Yes 2 No 3 Probably 4 Unknown			
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Vital	certificate rector, pag	25. Was case referre	ed to medical					-	Death (Check only	one)			
of V	Physician: this certific ral director, : To Be	1 Yes 2 W		Hospitel: 1 🗆 I	npatient 2	ER/Outpatier	t 3□ DOA C	ther: 412 Nursi	ng Home 5□ Re			ify)	
	ther the unera	27. Manner of Death	5 Pending	28a. Date of	of Injury h, Dey Year)	28b. Time of Injury		ury at ork?		e how injury occur	rred		
Division	tal or Attending P is after death. al Director: After t led in by the funers Certification:	2 Accident 3 Suicide 4 Homicide	invastigation 6 Could not be determined	28e. Place	of Injury - At ho ng, etc. (Specify	M 1 ☐ Yes 2 ☐ No signary - At home, farm, street, factory, office fc. (Specify)			28f. Location	28f. Location (Streel and Number or Rural Route Nur City or Town, State)			
	Hospi 24 hou Funer may fill												
	Mor day									29d. Date signe	te signed (Month, Day, Year)		
	201	MELITO M. TORRES, MD 441 S. ELLWood AVE, BALTO, MD 21224											
	State Registrar	31. Data filed (Month, Dey, Year) 32. Registrar's Signatura Security 32. Registrar's Signatura											

DHMH 16 Rev 6/95

ORIGINAL



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Vovenber 82000 9:45 AM William Edward Rowlins /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner ente Baltimore aguare Hospita If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Yeer Months Deys 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F 70 215-28-1725 9-18-30 Director MD Usual Residence of Decedent the Manyland 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other then "natural", or items 23s or 28s-f show traumatic event, the Medical Examinations to motified at 1 ☐ Yes 2 No Director MD Baltimore Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with USA 7905 Riverdale Avenue 21237 Funeral 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 PZ Yes 2 □ No If Yes, Give Year or Dates: Korean 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Stetus Black, White, etc. Kowlins, William 1 Never Married 25 Married Specify: White 1 ☐ Yes 2 No Specify. P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 72 th and Mental Hyglene. 7 Is marked other than "na Elementary/Secondary (0-12) College (1-4or 5+) Foreman Steel 12 Bethlehem 18. Mother's Name (First, Middle, Meiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Jordan William Rowlins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health are important: if Item 27 is any injury or other trau Betty Rowlins/Wife 7905 Riverdale Avenue, Baltimore MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 11-11-00 Baltimore, MD Metro Crematory 21. Signature of Funeral Service Libense 22. Name and Address of Facility Cvach/Rosedale Funeral Home Chesaco Avenue Baltimore MD 21237 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or es a consequenca of): Examiner Denia physician and s the burial-transit The law requires that the death certificate be associted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ancer Physician/Medical Due to (or as a consequence of): for use as a.s 980 ached 23b. Did tobacco use contribute to the cause of death? Part ff. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part f. signed by to 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Unknown p 24b. Were autopsy findings available prior to completion of cause of death? should b 24a. Was an autopsy performed? Completed certificate has t lirector, page 2 s 1 Yes 212 No 1 ☐ Yas 2 No Physician: Be 25. Was case reterred to medical 26. Place of Death (Check only one) Hospitel: 1 Suppatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 After this 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Physician 24 hours after death. It the Funerel Director: After this completely filled in by the funeral is 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending Investigation 1. Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide edical 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and mannar as stated. 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and dua to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature en title of certifier 29c. License number . M.D Movember Sth. 2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Registrar **DHMH 16 Rev 6/95**

State

MUDMINMD 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 68

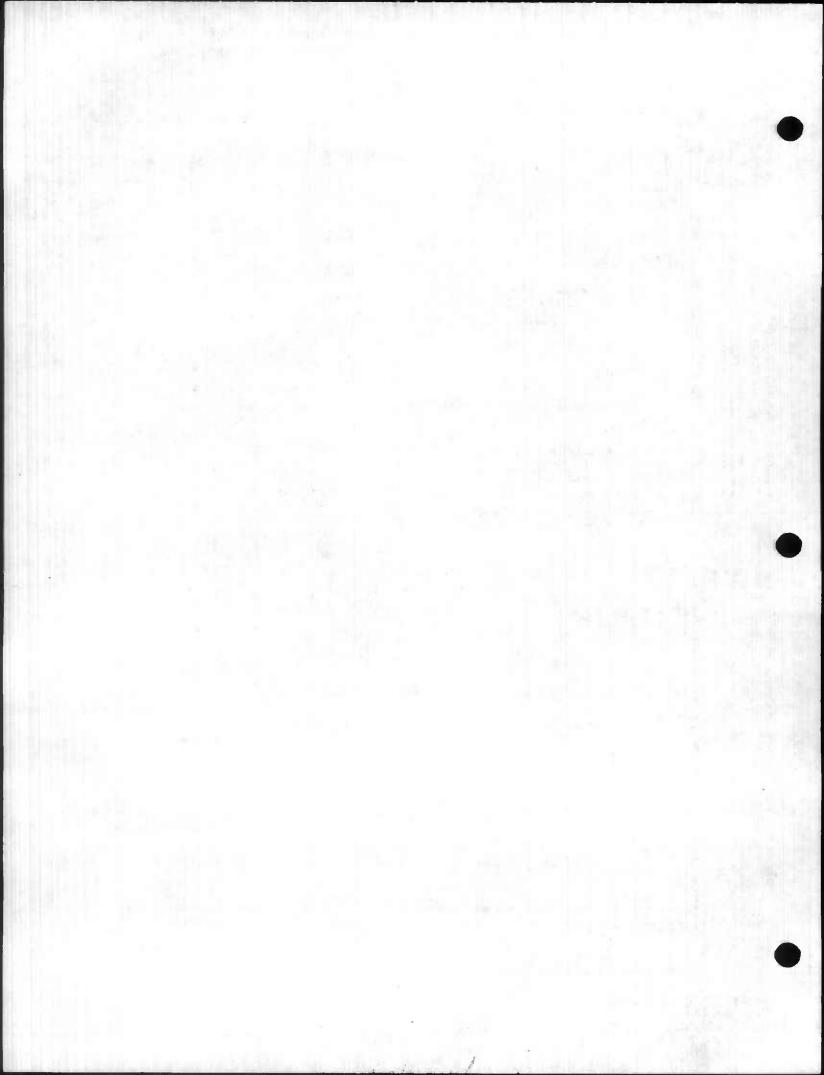
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32. Registrar's Signature

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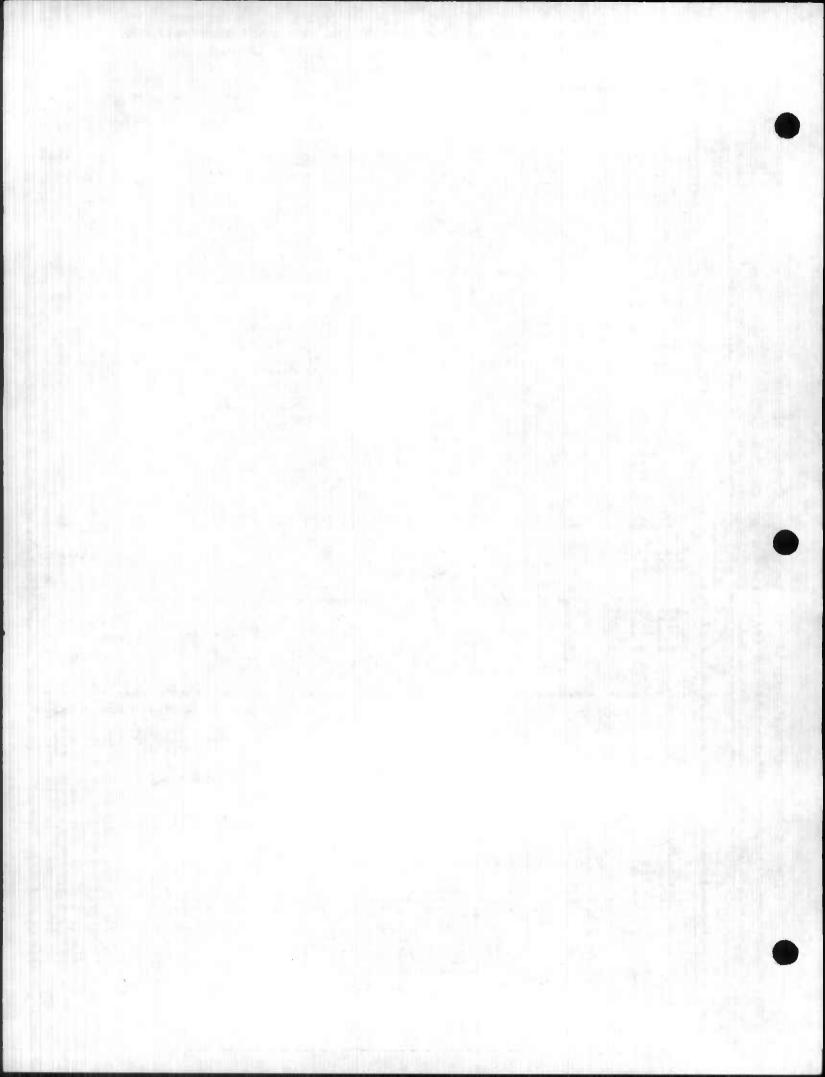
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State of Maryland / Department of Health and Mental Hygiene 36074 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 11, **Physician** 7:30 A.M. 2000 Mildred G. Sessa /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 5030 Orville Avenue If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Day, Year) Months Days Hours Min. July 15, 1930 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1□M 2×F Yrs. Maryland 70 220-24-7028 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Director Baltimore Maruland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21205 United States 5030 Orville Avenue Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 ò White 1 Yes 2 No Specify: à 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Cottege (1-4or 5+) Machine Operator Goetz's Candy 6 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Pages 1 and 2 should be nent of Health and Mental ant: If Nem 27 is merked o Blanche Bolding Edward Bullock 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5030 Orville Avenue, Baltimore, Maryland. 21205 Mrs. Linda Stran / Daughter 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, Maryland XBurial 2 Cremation 3 Removal from State b Department of Important: If any Injury or 11/13/00 Baltimore Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Baltimore, Maryland 21213 Maro 23a. Part1. Enter the diseaset or cut-rications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last The law requires that the death certificate be execut use as the burial-trar Box 68760, P.O. | Part II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Winknown 2 Division of Vitai Records, 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Certification: To Be Completed 1 ☐ Yes 2 ☐ No or Attending Physician: the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Sesidence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this Manper of Death Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No after death. 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) B 4 Homicide Within 29-bount **Certifying Phracian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 | Medical Evaryther: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. Medical (Check only å 29b. Signature and little of ce 29c. License number 29d. Date signed (Month, Day, Year) ed ceuse of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar

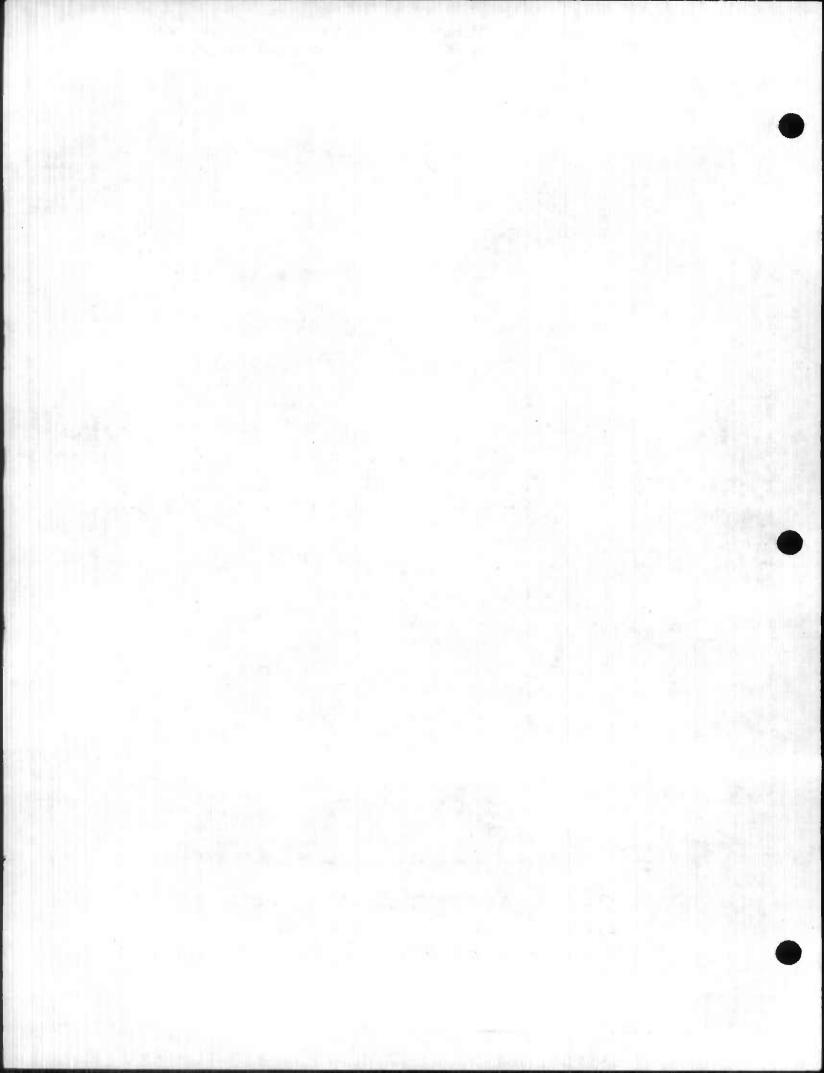
DHMH 16 Rev 6/95



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	Examiner	t as all	. /		11/1	20100	Darada		- 1	1			
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	Funeral	5. Social Security 409–22–		Pex I□M 25xF	ige (In yrs. last b 79	Yrs. Months Deys	Hours Min.	Dete of Birth (Month, Dey, Ye MAY 4 19.	37)	Birthplace (State or Foreign Country)			
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- 1	or 28s-f s be notified Director	10e. Street and I	Number			10f. Zip Code		10g.	Citizen of V	Vhat Country?			
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Maryland 21215-0036	af, or here 23 Examiner must by Funeral	1 Never M	erried 2 Merried	Armed Forces 1 Yes 2 H If Yes, Give Yeer or Detes	? FNo	It Yes, specify Cut 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Speciform, Mexican, Puerto Rid o Specify:	can, etc.)		k, White, etc.			
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Вох	e attended for ut												
. 1	the a hed f	Part II. Other sig	nificant conditions	contributing to death	but not resulting	in the underlying ceuse g	iven in Pert I.	23b. Dld tobac	co use co	ntributs to the cause of death?			
P.0	ed by the attending detached for use	Mana	. ab 11 = 1	ali a T	11.	asi Dira		1 Ves	2□ No	3 Probably 4 Unknown			
- 1	igned be determined by PI	CHOUN	UDSTY	ctive t	ulmon	ind Dise	056						
	should should been s	Corona	ury Arte	(y Disea	15e, +	typerten	sion	24e. Was an e- performed	utopsy 1?	24b. Were autopsy findings sveilable prior to completion of ceuse of death?			
	certificate has rector, page 2	Conso	Live H	sact Ta	11100			1 ☐ Yes	2 0 No	1 ☐ Yes 2K No			
	or. p	25. Was base re	terred to medical	BOUT FOR	note		26. Place of Death (
Vital		examiner?		Hospitel:		0	ther		. a 🗆	(0			
ō	53	1 Yes 2		nospitel: 1 Inpa		outpatient 3LI DOA	4 Nursing Home	d. Describe how i					
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Sic	r death. ector: Afte by the fune	2 Acciden	investigetion 6 Could not be			M 1[☐ Yes 2☐ No						
Division	after death Director: A In by the f	3 ☐ Suicide 4 ☐ Homicid	dataminas	289. Piece of I	njury - At home, etc. (Specify)	term, street, fectory, office	28	 Location (Stree City or Town, S 	t and Numb tete)	per or Rural Route Number,			
	San Dan				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,								
	within 24 hours after death. To the Funeral Director: After completely filled in by the funeral medical Certification.	29a. Certifier (Check only one)			of exemination e	ge, deeth occurred et the t and/or investigetion, in my							
13	M Maria	29b. Signeture a	nd title of certifier			29c. Licer	nse number	29d.	Dete signe	d (Month, Day, Year)			
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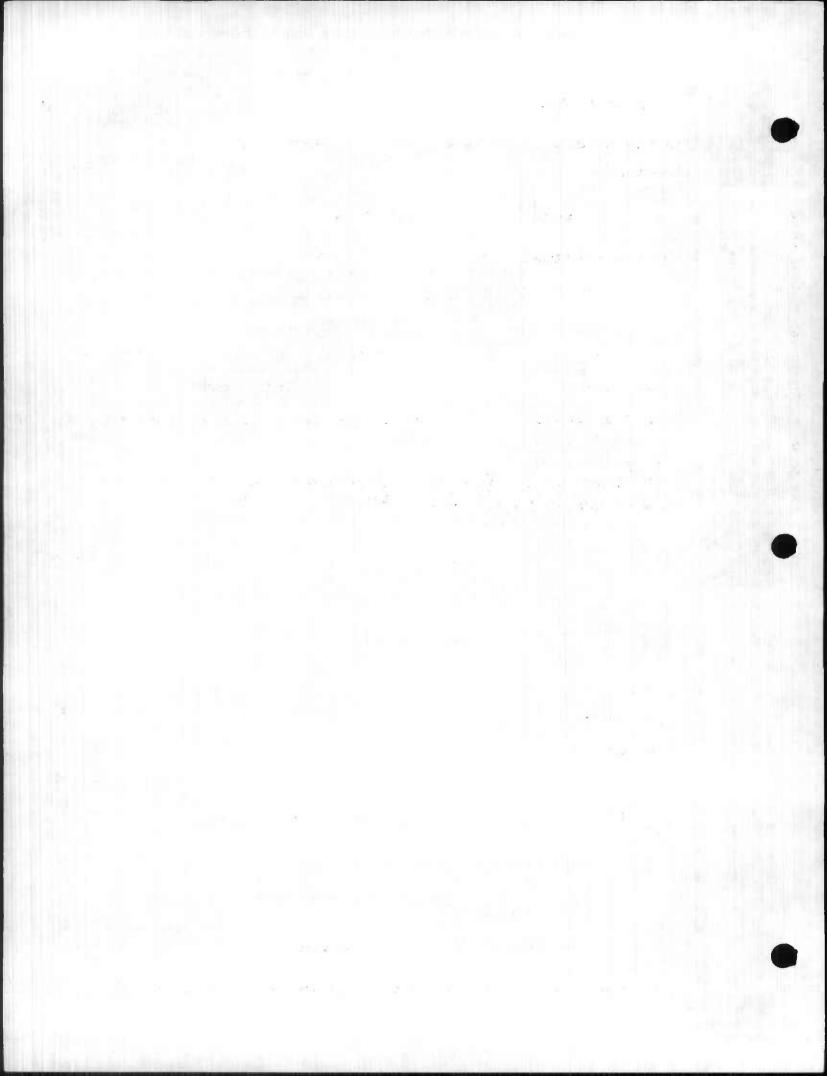
DHMH 16 Rev 6/95

State Registrar



				0011	tificate o	Dodin		Reg. No.		
sician	Decedent's Neme (First, Middle, I FRANK J. STO						2. Data of D Month	Day	Year	ma of Death
edical						4h City Town	Novemb or Location of Dea	-	2000	:43FN
miner '	4a Facility Name (If not Institution, g								312-212311	
	VA Maryland Heal 5. Social Security Number 6.		STEM ga (In yrs. last	birthday)	If Under 1 Ye	Perry P		Ceci	9. Birtholace /S	Stata or Foreign
ral tor	474-16-7314	1⊠M 2□F	79	Yrs.	Months Day		lin. 8. Data of Bi (Month, D Feb 9,	1921	Country	IN
	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Loc	eation				10d. Ins	ida City Limits
Director	MD Harfo	ord			de Gra	ace				Yes 2 No
- ire	10e. Street and Number				10f. Zip Code	•		10g. Citizen of	What Country?	
	300 Commerce St	reet #305			21	078		U	SA	
Funeral	11. Marital Status	12. Was Decedent Apped Forcas	Evar in U,S.	13. W	Vas Dacedant o	f Hispanic Origin?	(Specify Yes or Nuerto Rican, atc.)	o- 14. Rad Bia	ca - Amarican Indi	an,
	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 N Yes 2 ☐ If Yes, Give Yaar or Datas:	No		□Yes 2₩N			Specif		
Completed by	15. Decedent's	Educetion		6a. Decede	ent's Usual Occ	cupation		16b. Kind of B	usiness/Industry	
pie	(Specify only highest g Elementery/Secondery (0-12)	college (1-4or	5+)	life. D	OO NOT use ret	ne during most of ired)	working			
PO	8	0	0.,	fa	rmer			agri	culture	
Be	17. Father's Nema (First, Middle, La	st)					Neme (First, Middle		me)	
To	Frank Stolka					Mari	e Dersak			
	19a Informant's Name/Relationship Betty Stolka/spo					ef and Number of	#305 H		Grace, M	
	20a. Method of Disposition 1 Burial 2 Cremation 3	Domousi from State	0.000	of Dispos	sition (Name of patory or other p	olace)	Date	20c. Location	- City or Town, St	ata
	4 Donation 5 Other (Spec	cify)								
	21. Signature of Suneral Service Lio	Wade Dir	ector	22 S	Name and Ad	dress of Facility Bo	ard 655	W. Balt	imore St	treet
	Manain	11/100	10		altimor		21201			
	Pant. Enter the disease, for co	implications that cause	ed the death. I	o not ente	er the mode of o	tying, such as cere	diac or respiratory	arrest,	Appro	oximate at Between
		., 0.10 00000 011 00011								t and Death
ıl	Immediate Cause (Final disease or condition	Colon	Cancer						Unk	nown
r	resulting in death)	a	Due to (or es		uence of):					
ner										
Examiner	Sequentially list conditions,	0.	Due to (or as	a consequ	uence of):					
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	C								
VMedical	that initiated events resulting in death) Last		Due to (or as	a consequ	uenca of):					
N/Me		d							t	
Physician	Part il. Other significant conditions	contributing to death	but not resultin	g in tha un	derlying ceuse	given In Part I.	23b, Die	d tobacco use co	ontribute to the c	ause of death?
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by	Hypertension								1	
Completed by P	Multiple Sclero	sis					24a. Wa per	s an autopsy lomed?	24b. Were aut avaltable complation	opsy findings prior to on of causa
mpi									of death?	
								Yes 2 No	1 □ Yas	2[XNo
Be	25. Was cese referred to medical examiner?	Hospitel:				Other	Death (Check only			
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tlon	1 X Netural 5 ☐ Pending	(Month, D	ay Year)	tnjury	V	Vork? ☐ Yes 2 ☐ No	_33. 5666100		-	
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ert	4 Homicide		tc. (Specify)				City or To	own, State)		
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edical	29b. Signature and title of certifier Samir	theiri		-) /=		52064		Nov	11,200	0
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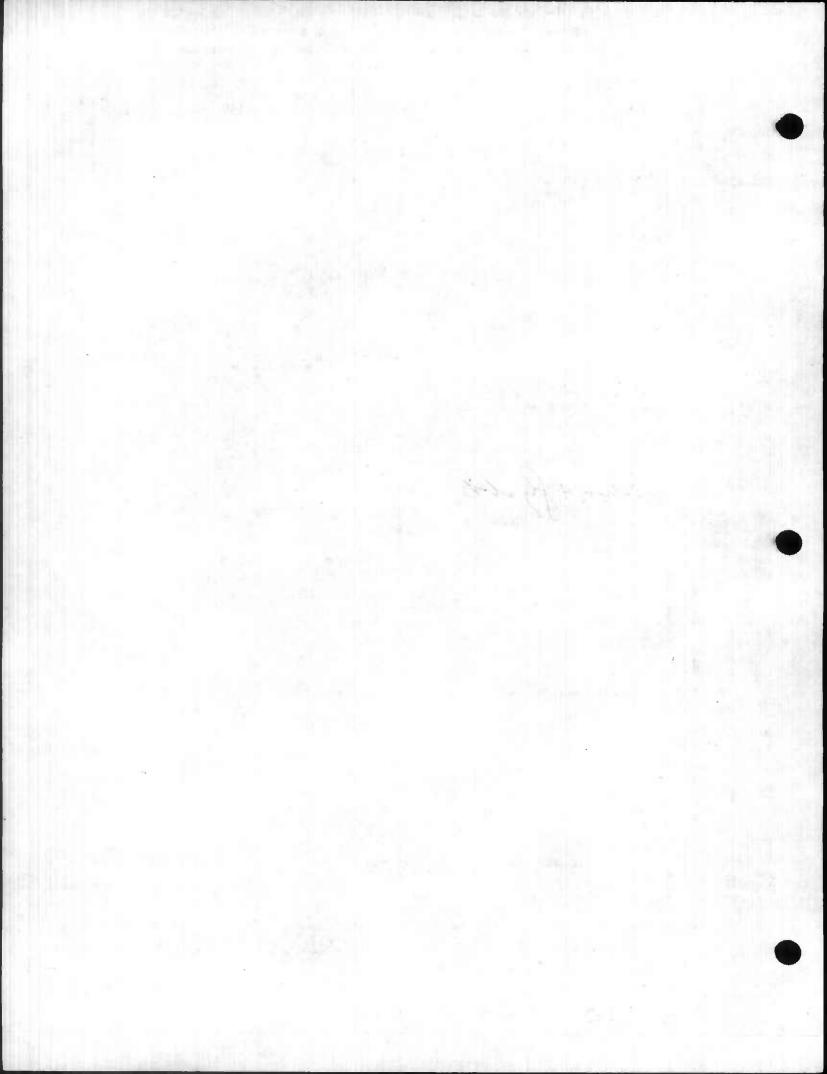
State Registrar



State of Maryland / Department of Health and Mental Hygiene 36077

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tor	M.	aryland	N/A			Ва	ltimor	e			Yas 2					Yas 2 N	
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runeral	11	. Marital Status		12	. Was Decedent Armed Forces		J,S. 13.	Was Dec	edent of I	lispanic Ori an, Mexicar	gin? (Spo	ecify Yes or N Rican, etc.)	lo- 14.		- Amaricai , Whita, at		٦,
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Completed	17	. Father's Name	(First, Middle	Last)			Secre	lary		18, Moth	er's Name	e (First, Middl	Priva			01	
o Be		Rollo H.									Brov			30			
F		9a. Informant's N			a Print)	70.10	19b Maili	no Addre	es (Strae			VII al Route Num	ber, City or T	Town S	State Zin (Code)	
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Important: if hem 27 any injury or other tr shoe.	_	Daniel A. Himes/Son P.O. Box 703 Lawno 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State P.O. Box 703 Lawno cametery, crematory or other placa)										Data	28090 20c. Loca	ation - C	City or Tow	m, State	8
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	2	I. Signature			2	Me	tro Cr			LNC . ass of Facili		1-9-00	1 Ba	alti	imore	, M	D
		Red	uns/A	K	, all			Crem	ation	n Soci	ety	ety of MD, Inc.					
_	2	Edwar	d A! G	7980	Archik 299 Frederick Road Ba Bications that caused the death. Do not enter the mode of dying, such as cardiac or raspirat one cause on each line.							l Balt	altimore, MD 21228 altory arrest, Approximate Interval Between				
s the burkel-transit edical Examiner	di	nmediate Cause sease or condition sulting In death)	on	a.	ASPIR	Due to (ON or as a conse	eng	Cup								and Death
edical Examiner	di re	sease or condition	onditions, mmediate erlying I njury		ASPIR	Due to (or as a conse	Q NO quence o	Cur): +cce:	hina							
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physician** Edward Stephen Stengel November 9. 2000 10:00 PM /Medical 4a Facility Nama (Il not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Agnes Nursing and Rehabilitation Center

Social Security Number

6. Sex
7. Age (In yrs. last birthday)
Months Days Ellicott City Howard 5. Social Security Number 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) **Funeral** Yrs. Director 216-10-6655 Hungary SEP 10, 1908 Usual Rasidence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yas 2 No Director Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3000 N. Ridge Road 21043 Funeral USA 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Meritat Status Black, Whita, etc. 72 hours after 1 ☐ Yas 2 ☐ No If Yas, Giva Year or Datas: 1 Never Married 2 Married Baltimore, Marviand 21215-0020 1 ☐ Yas 2 No Specify: P Specify: 3 □Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be flied within 72 Department of Health and Mental Hygiene. Important: if Itam 27 Ia marked other than "nation plury or other traumatic avent, the Medical PAGE. Elementary/Secondary (0-12) Collega (1-4or 5+) Building Contractor Construction 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Be 2 Styepan Stengel Julka Schmidt 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Marlene M. Schmidt/Cousin 60 Open Gate Court Baltimore. MD 20b. Place of Disposition (Nama of cematary, crematory or othar place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 Cremation 3 Removel from State 4 Donation 5 DOthar (Specify) Good Sheppard Cemetery 11-13-00 Ellicott City, MD 21. Signature of Funaral Service Licensee 22. Name and Address of Facility
MacNabb Funeral Home P.A. George MacNabb 301 Frederick Road Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final week · BILATERAL PNEUMONITIS disease or condition resulting in death) Examiner Dua to (or as a consequence of) Examine attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Box 68760. Physician/Medical Due to (or es a consequence of): P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ATRIAL FIBRILLATION COROWAR Records. g 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy Advanced HEART DISEASE. 1 ☐ Yes 2 No 1 □ Yas 2 No REMENTIA Division of Vital 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) OL this funeral 28a. Data of tnjury (Month, Day Year) To the Hospital or Attanding Plantin 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 27. Manger of Death 28c. triury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28t. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

Registrar

29b. Signature and title of certifie

NORBERTO M. MACHIRAN, MD. 720-CMAIDED CHOICE LA. BALTO. MD. 21228 31. Data filed (Month, Day, Year) 32. Registrar's Signatura NOV 1 4 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

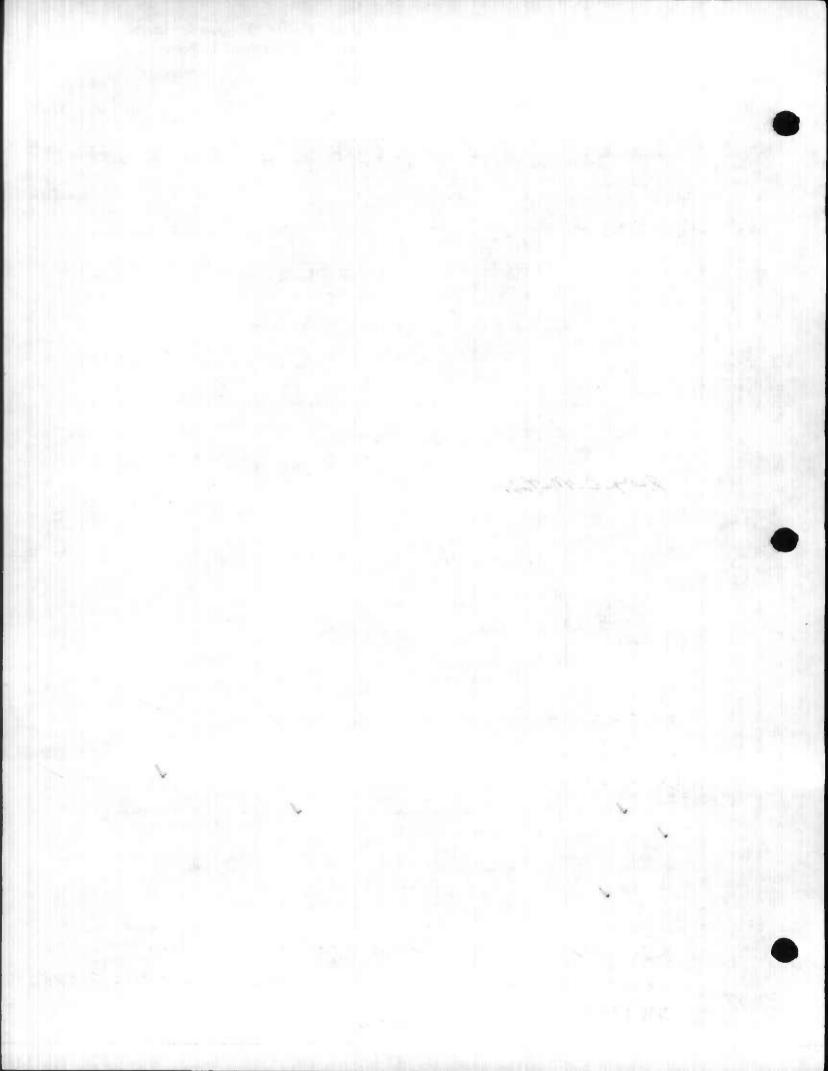
Sparker

ATTENDING Physician D16200

29c. License number

29d. Data signed (Month, Day, Year)

November 10, 2000



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 8:50 AM 2000 Stewar November Eugene /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore V.A. Medical Bultimore Center City N/A If Under 1 Year If Under 24 Hrs. 8. Dete of Ren (MoNey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Deys Hours 1 M 2 F Months Yrs. 225-38-2859 Director 68 July 17, 1932 Virginia Usual Residence of Dec Peges 1 and 2 should be filled within 72 hours after deeth with the Maryland nent of Health and Mentel Hyglans.

ant: if Idem 27 is marked other than "natural", or hems 23s or 28s-f ahow any or other traumatic avent, ma Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits YE Yes 2 No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1261 James Street 21223 Funeral United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 12. Wes Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 TYes 2 No
If Yes, Give
Year or Dates 1953-1955 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maintenance School System 8 Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) 8 Emmett Lee Stewart Ethel Madeline Ayers 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emma A. Stewart/ Wife 1261 James Street Baltimore, Maryland 21223 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Pege Depertment of Important: if eny injury or pace. 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial Park | 11/13/00 Sykesville, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Fecility Hubbard Funeral Home, Inc. Roman Manuta 4107 Wilkens Avenue Baltimore, Maryland 21229 23a. Perft. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock or heart tailure. List only one cause on each line. Approximate Interval Between Onsel and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 2/ days Examiner Due to (or as a consequence of): Physician/Medical Examiner cicrhosia the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. physician Due to (or es a consequence of): for use as P.0. Part II. Other algalificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, á 24b. Were autopsy findings available prior to completion of cause of death? Certification: To Be Completed 24a. Wes an autopsy After this cartificate has 12 Yes 2 No 1 Yes 2 No Physician: 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 12 Inpatient 2 ER/Outpatient 3 DOA . Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation after death. Director: A 1 Yes 2 No 8 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospira with 24 hours after di To the Funeral Direct To the Funeral Direct To the Funeral filled in by 3 Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 124 Contriving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Hadical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) November 3 909 W. Uniwasity 308 Bultimore, MD Sima Senas PKW NUV 1 31. Date filed /Month 32. Registrar's Signature

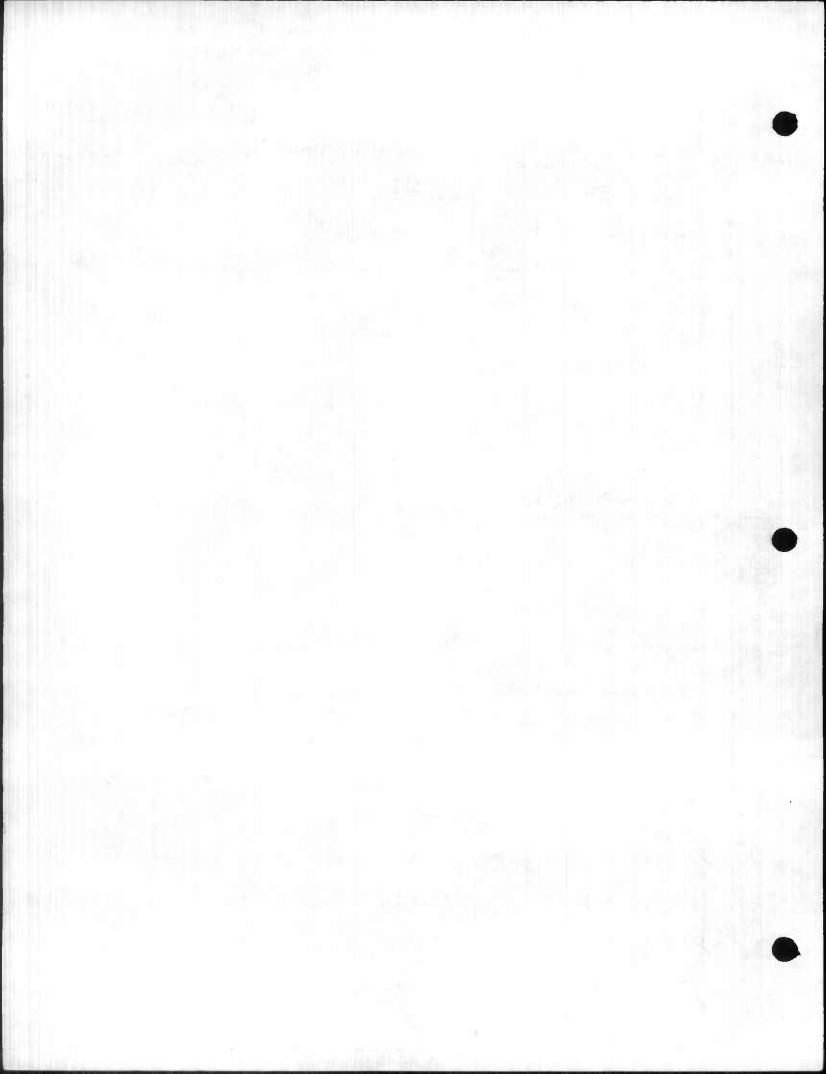
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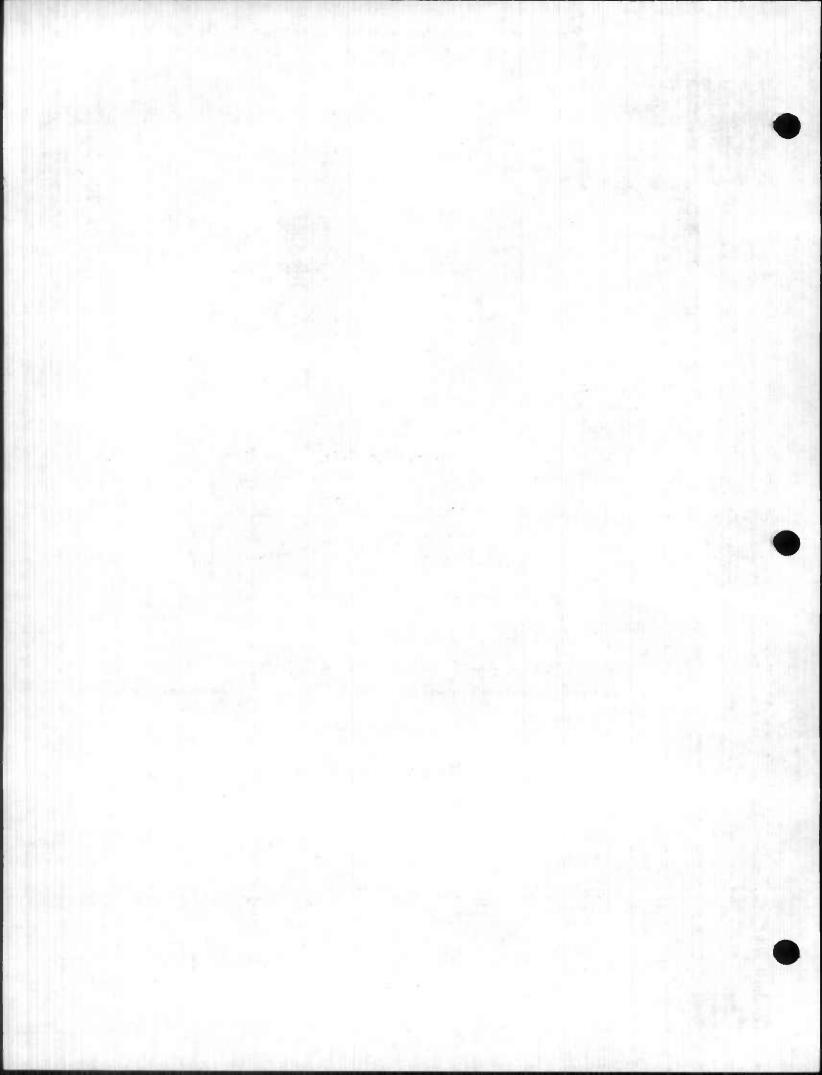
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Examiner must be notified at Examiner must be notified at by Furneral Director	11. Maritel Stetus 1 Never Men 3 Widowed	ried 2 Merried 4 Divorced	12. Wes Deced Armed Ford 1 DYes 2 If Yes, Give Year or Det	es?	S. 13	. Wes Decedent of I If Yes, specify Cub	dispento Origin? (Spien, Mexicen, Puerto Specity:	ecify Yes or No- Ricen, etc.)	Blac	e - Americe k, White, e	tc.		
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edical C	29a. Certifier (Check only one)			is of examina			me, dete end plece, opinion, deeth occurr						
M W	29b. Signature and	title of certifier			M 2	29c. Licen		2	9d. Date signed				
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1		30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) SHOAII3 A. HAS Hm1, S21 N. Enlaw St Inte 308, Balt. mp 21											
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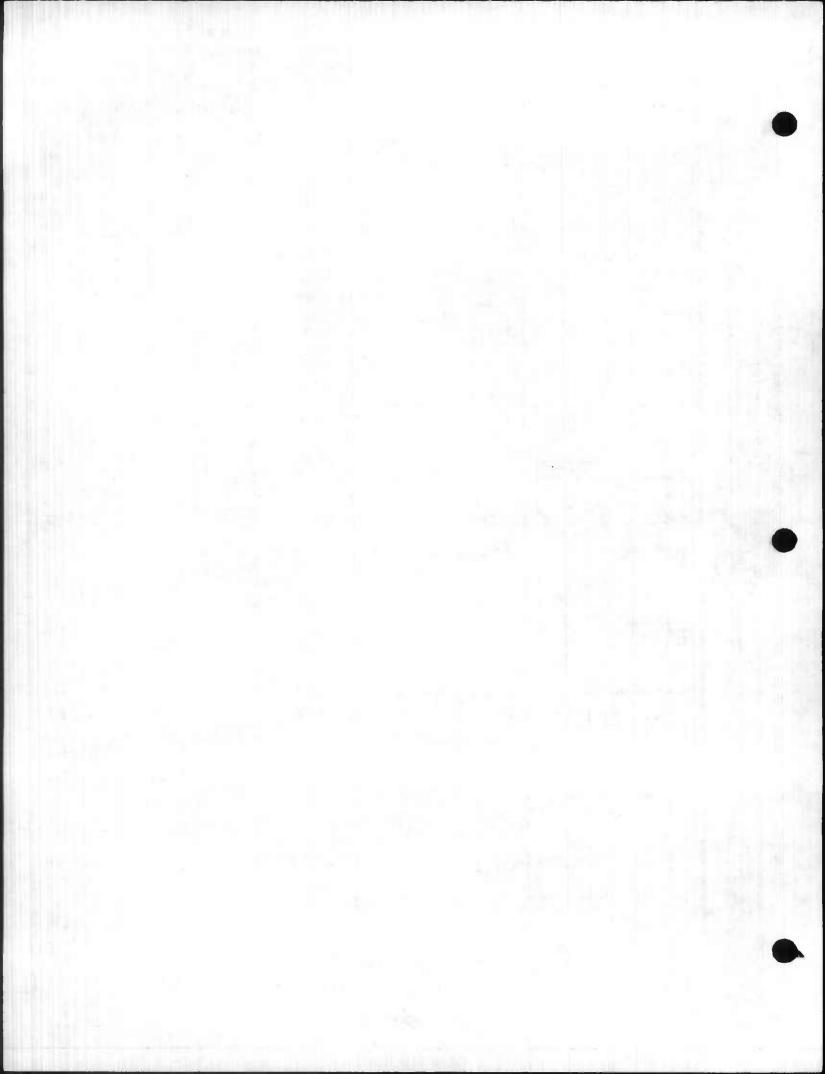
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	Decedent's Name (First, Middle, La.	st)		Certificate o	Death	2. Date of Dea		3. Tima of Deat		
hysician /Medical	JERRY	LYNN	SI	EELE		Novemb	IER 8 2	000 8:25 F		
Examiner	4a Facility Name (If not institution, giv				4b. City, Town, or L		4c. County o	Death		
			OSPIT			WENTE	ANNE			
uneral rector	5. Social Security Number 6. S 219-38-2987	Sex 7. Age	(In yrs. last birtl	Months Day		8. Date of Birth (Month, Day JUNE 2	Year) 6,1941	9. Birthplace (Stata or Fore Country) VIRGINIA		
N N	10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Lim		
28e-fat notified rector	MARYLAND ANNE AL	RUNDEL	GI	EN BURNIE				1 ☐ Yes 2 💢		
he notified Director	10e. Street and Number			10f. Zip Code	•		nat Country?			
	354 MAE ROAD				21061		.A.			
Examiner must by Funeral	11. Merital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Was Decedent II Armed Forces? (CXYes 2 N If Yes, Give Year or Dates:		13. Wes Decedent of If Yes, specify Co	f Hispanic Origin? (S) uban, Mexican, Puerto lo <i>Specify:</i>	pecify Yes or No- Rican, etc.)	14. Rece Bleck Specify:	- American Indien, , White, etc. WHITE		
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Be see	17. Father's Name (First, Middle, Last)		18. Mother's Nem							
To The	ELMER		STEELE		MARGARET ATLIZER sss (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)					
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shoul shoul						24a. Wes e perfor	en eutopsy med?	24b. Were autopsy findin available prior to completion of cause of death?		
Com Com						1□ Y	es 2 No	1 ☐ Yes 2 XNo		
B ector	25. Was case referred to medical examiner?			1		th (Check only or	ne)	1		
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d in by the funer Certification:	2 Accident 3 Suicide 4 Homicide investigation 6 Could not be determined	building, etc	(Specify) I my knowledge, examinetion and	death occurred at the	time, dale and place,	end due to the c	ause(s) and men	ner as slated. nd due to the cause(s)		
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Maryland 21215-0020

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The law requires that the death certificate be executed

Box 68760.

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Division of Vital Records.

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State of Maryland / Department of Health and Mental Hygiene (1) Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death .Physician Smith Byron Champness November 07, 2000 1646 pm /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Deeth Examiner 2910 Goodwood Road, Apartment B Baltimore N/A If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Yeer) 8-19-34 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□ F Months Days Hours Yrs. 66 MD Director 219-30-6244 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Directo N/A Baltimore MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21214 USA 2910 Goodwood Road Apartment B Funerai 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14 Bace - American Indian Bleck, White, etc. 1 ⊠ Yes 2 □ No
If Yes, Give
Yeer or Detes: 1957–63 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: by 3 ☐ Widowed 4 ☑ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Tavern Tavern Owner 12 0 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Be Evelyn Champness Byron N. Smith 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 7935 31st Street, Baltimore, MD Mabel Smith/ Ex-Wife 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removal from Stete permit. Page Department of Important: If any Injury or once. 4 □ Donetion 5 □ Other (Specify) Highview Memorial Garden 11-10-00 Baltimore MD 21. Signeture of Funeral Service Incenses 22. Name end Address of Fecility Cvach/Rosedale Funeral Home Chesaco Avenue Baltimore, MD 21237 23a. Pert¹. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete ntervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that lettled events.) Due to (or es a consequence of): that initiated events resulting in deeth) Last Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 □ Yes 2 □ No 3 □ Probably Unknown py 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed Yes 2 No 1 Yes 2□ No 25. Wes case referred to medical 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Mother (Specify) at scene 1X Yes 2□ No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Mennes of Death 28a. Date of tnjury (Month, Day Yeer) 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner as stated.

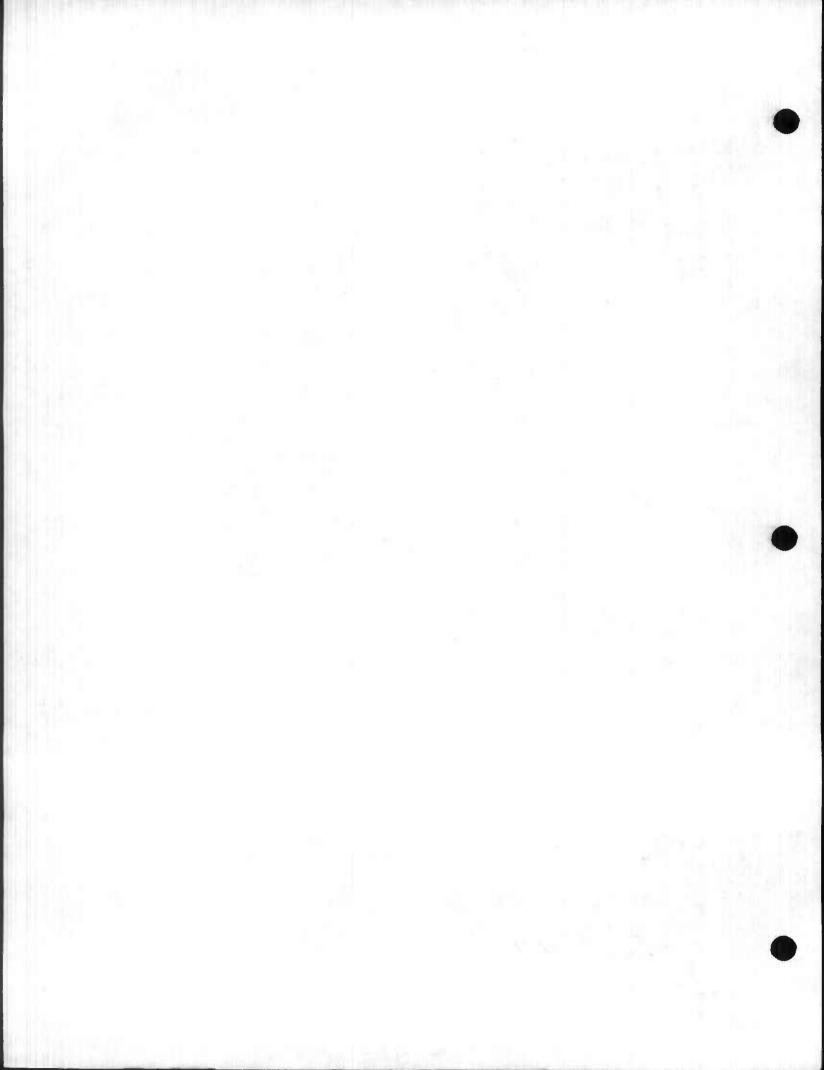
Wedical Examiner: On the basis of examination and/or Investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Dete signed (Month, Day, Year) 29c. License number 29b. Signature end title of certifier O.C.M.E. November 08, 2000 nes 30. Name end address of person who completed cause of beath (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 Miksu HERONE

State Registrar

31. Dete filed (Month, Day, Yeer)

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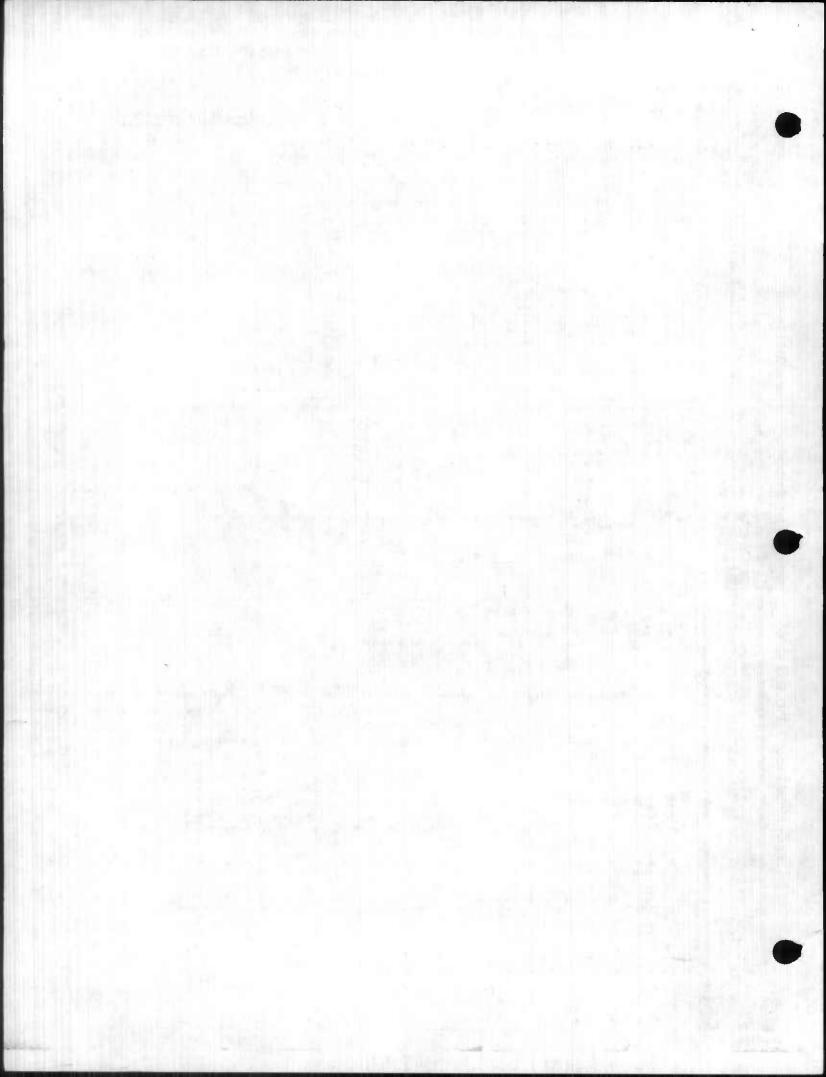
32. Registrer's Signeture



		State of		Department of F Certificate of	lealth and Mental Hy Death	/giene	0 36083
	Physician /Medical Examiner	1. Decedant's Neme (First, Middla, Last) RICHARD 4a Facility Nama (If not institution, give street and not HARD BOR HOSPITA	E, mber)	STRIK	2. Data of Dr. Month Ab. City, Town, or Location of Deat Broad town (NC)	ber 8,2	Year 3. Tima of Death
	Funeral Director	5. Social Security Number 6. Sex 1 M 2 F 215 03 2248 1 M 2 F Usual Rasidence of Decedant	7. Age (In yrs. last bird	thday) If Under 1 Year Months Days	if Undar 24 Hrs. 8. Dala of Bi Hours Min. 8. March	rth ay, Year) 10,1916	9. Birthplace (State or Foreign Country) Pennsylvania
	Maryland of ahow	10a. Stata 10b. County Maryland Anne Arundel	10c. City, Town	imore			10d. insida City Limits 1 ☐ Yas 2 ☑ No
:	N with the Ma 13a or 28a-f a 1 be notified al Director	10e. Street and Number 4 W. 3rd Avenue		10f. Zip Code 2122	25	10g. Citizan of W	
020	within 72 hours after death with the Maryland ene. Than "natural", or items 23s or 28s-1 show the Medical Exerciner must be notified at empleted by Funeral Director.	11. Merital Status 1 Never Merried 2 Merried 1 Never Merried 2 Merried 3 Widowed 4 Divorced 12. Was Dec Armed Fi 1-7 Yes Si Yes or D	2 □ No iva	13. Was Decedant of H if Yas, specify Cub	dispante Origin? (Specify Yes or Nan, Mexicen, Puarto Rican, atc.) Specify:	o- 14. Race Blac Specify	e - Amaricen Indian, k, Whita, atc. White
15-0	"natural", ofcat Engleded by	15. Decedent's Education (Spacify only highast grade completed)	16a.	Decedent's Usual Occup (Giva kind of work dona lifa. DO NOT use ratire	oation during most of working	16b. Kind of Bu	siness/Industry
Maryland 21215-0020	77 -	Elementery/Secondery (0-12) College (1-40r 5+)	Foreman	18. Mothar's Nama (First, Middle	Warel	
lanc	B a g a	17. Father's Nama (First, Middla, Last) Herbert	Strine		Florence		a)
	rthar rthar rthan	19a. Informant's Name/Ralationship (Type, Print) Lillian C. Strine /		Mailing Address (Street W. 3rd Aver	and Number or Rural Routa Numbure Baltimo		Stata, Zip Coda) land 21225
o .	5 7 2 0	20a. Method of Disposition 1 Burlel 2 □ Cremation 3 □ Ramoval from 4 □ Donation 5 □ Othar (Specify)	Stata cematar	Disposition (Name of y, crametory or other pla Cross Cemete	11 /11 /0		City or Town, Stata
F	Demir Base	23a. Pent1. Entar tha disease, or complications that shock, or haart fallura. List only ona ceusa of the diseasa or condition rasulting in death)	Sepsis	not antar tha mode of dyl	Gonce : ie Highway Bal	timore, 1	Home P.A. Md. 21225 Approximate intervel Batween Onsat and Death
	death certificate be associted e attending physicien and of for use as the burial-transit siclaryMedical Examiner	Sequentially list conditions, if any, leading to immadiate causa. Enter Undarlying Causa (Disaasa or injury thaf initiated evants rasulting in death) Last	nfeation	consequence of):			
P.O. B.	and the death of by the atter deteched for r Physicial	Part II. Other eignificant conditions contributing to d	leath but not resulting Ir	n the underlying ceusa gi		tobacco use col	ntribute to the cause of death?
Records,	been signi should be)		24a. Wa	s an autopsy formed?	24b. Wera autopsy findings available prior to complation of ceuse of death?
Œ	The law ate has page 2				1	Yas 2X No	1 ☐ Yas 2 ☐ No
of Vital	entific ector.	25. Was casa rafarred to medicel examinar?		_ 0	26. Placa of Death (Check only		
	T digital	27. Menner of Death 28a. Data		Time of 28c. Inju	4 Nursing Homa 5 Has	how injury occur	
Division	is for Attanding P is after death. If Director: After t ed in by the funers Certification:	2 Accident Invastigation 3 Suicide 6 Could not be			Yas 2 No 281. Location	(Straat and Numb	er or Rural Routa Number,
	Funer flesh fill	29a. Certifiar (Check only 2 Medical Examiner: On that	e best of my knowledge	, deeth occurred et the ti d/or invastigation, in my	me, deta and piece, end due to tho opinion, deeth occurred at the time	e ceusa(s) and ma	inner as stated. and due to the ceuse(s)
	To the	29b. Signatura and titla of certifial ARUKALLY	NO MA	29c. Lican ## ## ## ## ## ## ## ## ## ## ## ## ##			ber B, 2000
	State	30. Nama and addrass of person who completed cau \$1 R * Medicar *	sa of death (Item 23a) (MHH BOO Registrar's Signatura	(Type, Print)	1386 L. Hanner S	West 1	Butmare, MD

DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name /First Middle Last 2. Date of Death 3. Time of Death WOV **Physician** 2:07 PM Charles Edward Smoot , 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner GIEN BURNIE NORTH ARUNDEL HOSPITAL AA COUNT If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1**X** M 2□ F Yrs. 215 30 0407 Director June 28,1934 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Director Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? Items 23a or 1106 Leonard Drive 21060 U.S. Funeral 12. Was Decedant Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Raca - American Indian, Black, Whita, atc. 1X Yas 2 No 1957— If Yes, Give Year or Dates: 1959 1 Never Married 2 Married b 1 Yes 2 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorcad 1959 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6th Supervisor Warehouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Mary L. Ebert Charles L. Smoot 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Myrtle M. Smoot / Wife 1106 Leonard Drive Glen Burnie, Maryland 21060 mportant: If Item 27 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages ment of 1 ■ Burial 2 □ Cremation 3 □ Removal from State à 11/14/00 Crownsville, Maryland Md. State Veteran Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 ramerousa recations that causad the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, one cause on each line. **Physician** Due to (or as a consequence of):

Active Scile 8 PS 5

Dua to (or as a consequence of): /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Physician/Medical Examiner eral Director: After this centificate hes been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Parkin Sonifm Box 68760. Dua to (or as a consequenca of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Tabehes Division of Vital Records. P Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 21 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 1 ☑ Natural 28d. Describe how injury occurred 28c. Injury at Work? al or Attending F 5 Pending investigation 1 Yes 2 No 2 Accident 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at Tothe Funeral D Hospital 24 hours a 12 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D14/36 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DALJIT S. SAWHYEY Son HE 201 Crain Towers Glan Beronie

MD 21061

DHMH 16 Rev 6/95

State

Registrar

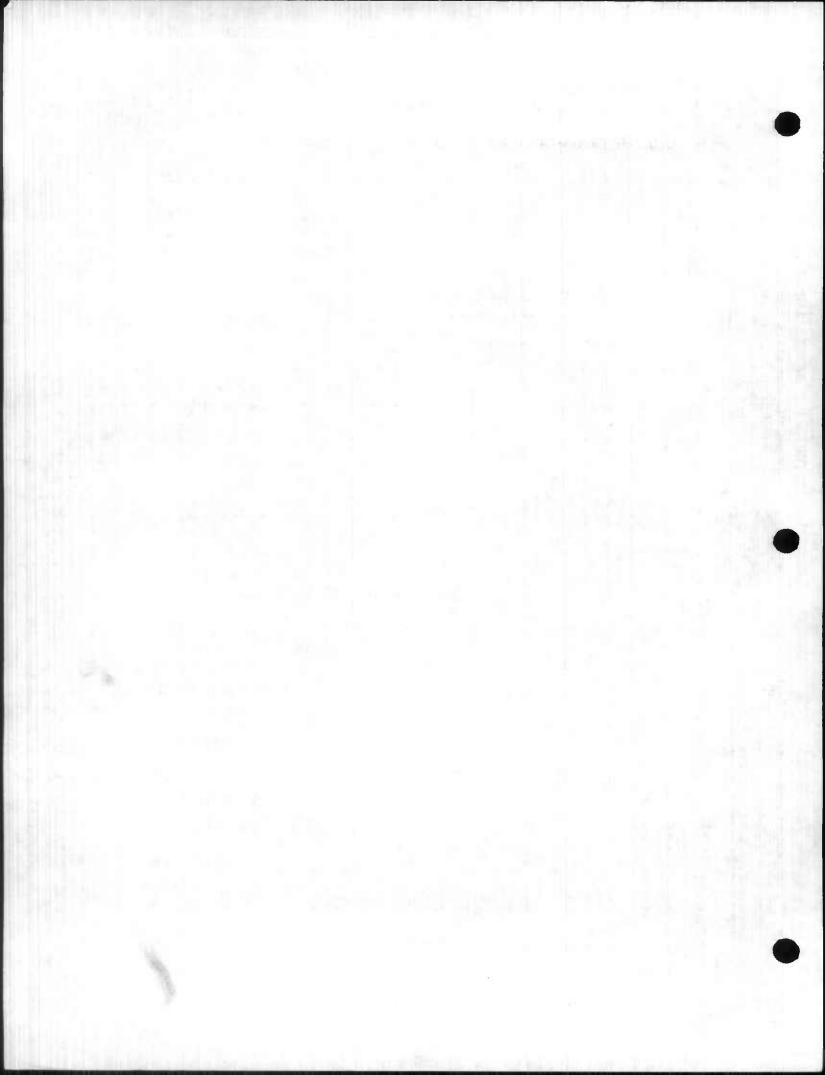
31. Date filed (Month, Dey, Year)

NOV

14 2000

32. Registrer's Signature

Densura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item#15 perFHG790 12/14/2000 EW Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Month 5:23 PM **Physician** November Doris L. Schultz /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Hunder 1 Year | Hunder 24 Hrs. 8. Dete of Birth (Month, Day, Year) ANNEARUN NORTH 5. Social Security Number ARVNDE HOSPIT 7. Age (In yrs. last birthday) **Funeral** 1□ M 25 F 220 24 4677 Director 82 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits must be notified at 1 Yes ZX No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 69 Wileys Lane Нота 23а 21122 U.S. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 11. Merital Stetus Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 1 Never Married 2 Merried "natural", or 1 Yes 2 No Specify: à 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. other than "n Elementery/Secondary (0-12) College (1-4or 5+) Tech. Writer Westinghouse 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be fill Department of Health and Mental Hy Important: if Item 27 is marked oth any Injury or other traumatic event abds. Dora May Hines Ernest W. Dev 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Janice Adams / Daughter 69 Wileys Lane Pasadena, Maryland 21122 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State Dete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 11/13/00 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 21. Signature of Funeral Service Licensee 22. Neme end Address of Fecility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 lone or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, List only one cause on each line. Onset and Deeth **Physician** Cardiomyopathy Immediate Cause (Finel disease or condition resulting in deeth) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Exami Aortic that initiated events resulting in death) Last Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 3 24b. Wera autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed 2 PNo 21 No 25. Wes case referred to medical examiner? 88 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA 28a. Dete of tnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation

Division of Vital Records, P.O. after A

Baltimore, Maryland 21215-0020

Schultz,

Certification:

1 Netural 2 Accident 3 ☐ Suicide

29a. Certifier (Check only one)

6 ☐ Could not be 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated.

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

IN MD

1 Yes 2 No

29d. Date signed (Month, Day, Year)

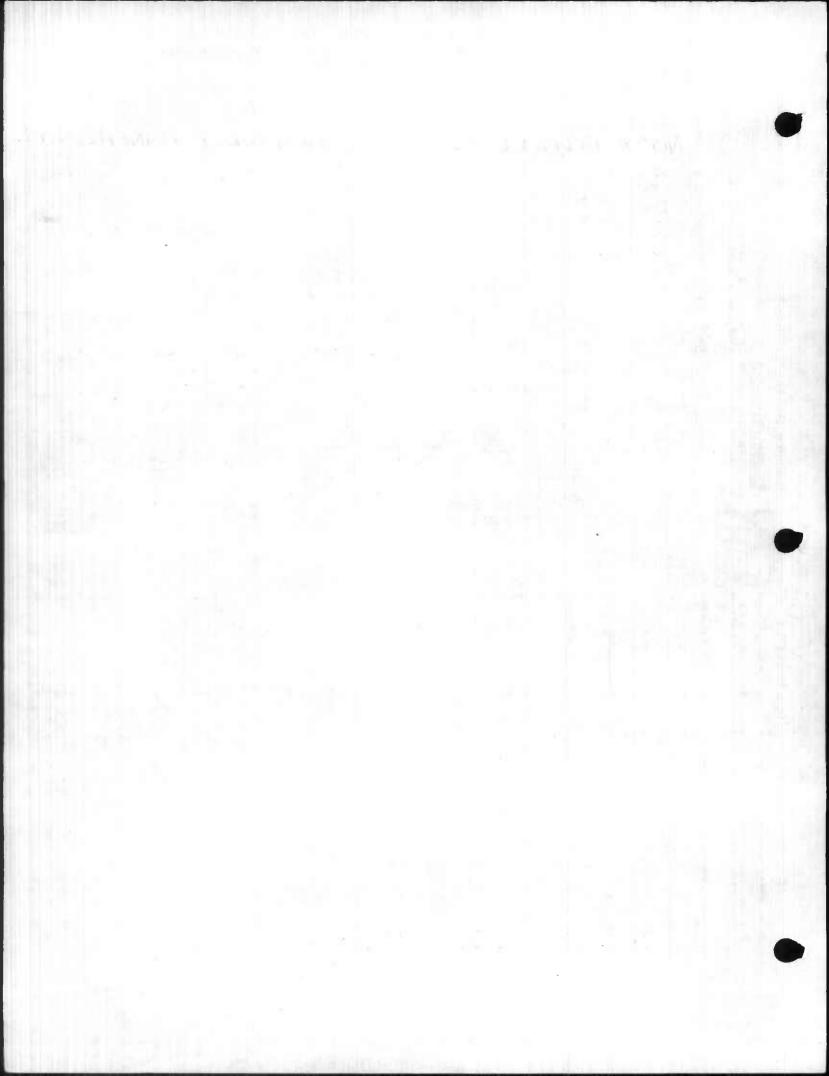
28f. Location (Street end Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital Drive, Glen Burnie, MD Gervae 31. Date filed (Month, Day, Year)

State Registrar

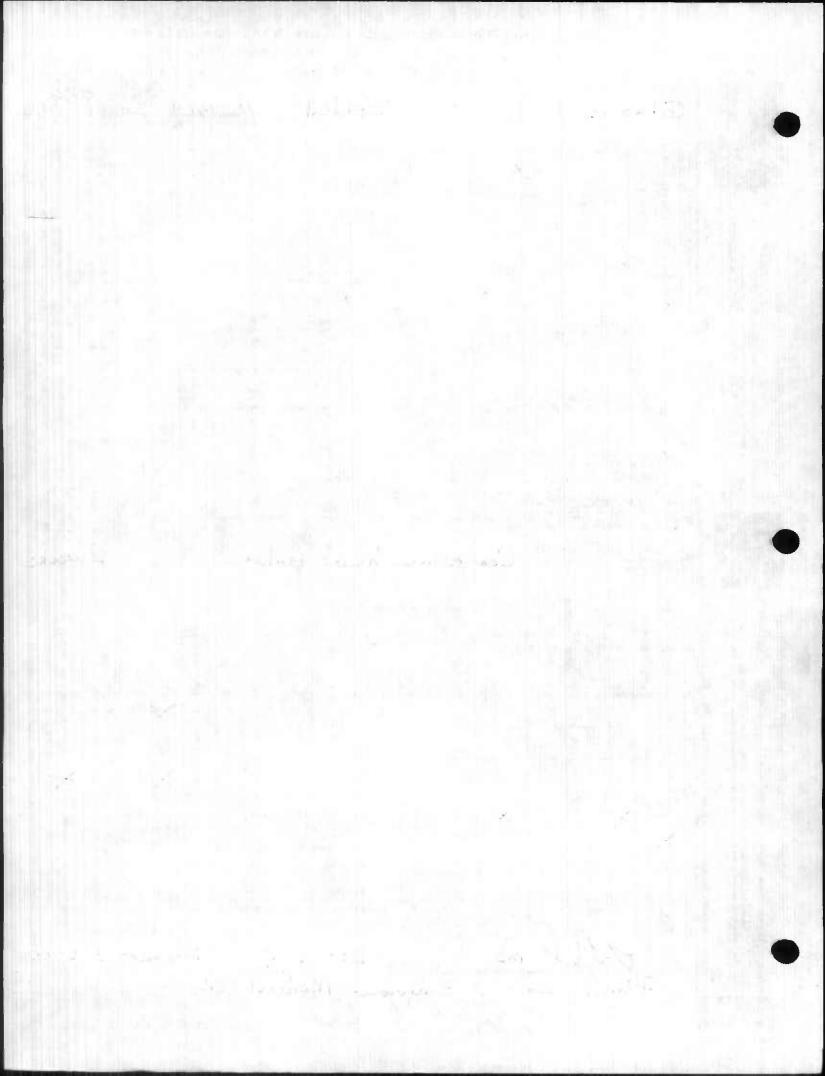
32. Registrar's Signature

Within P



	Amended	Ite	en#10d perFHG790 12/5/		f Marylar		rtment of tificate o		id Mental Hy	/giene Reg. No.	36086
4-	Physiciar /Medica	1	1. Decedent's Neme (First, Middle, Last		nheri		Spic	Jell 4b. City. Town	2. Dete of D Month OVEM	3629 2	Year & Small Harm
	Examine		Johns Hopkins						ore Cit	v N	/A
	Funeral Director	2	30-42-0217	ех □ м 2 74 F	7. Age (In yrs. 75	last birthdey) Yrs.	If Under 1 Ye Months De		Min. 8. Dete of B (Month, D Mar,	irth Year) 925	Birthplece (State or Foreign Country) W
	dand me	-	Usual Residence of Decedent 10a. Stete 10b. County		10c. C	ity, Town or Loc	eation				10d. Inside City Limits
	Many		Md Baltim	ore		Dundal	.k				1 Yes 25 No
	death with the Maryland ms 23a or 28a-f show image to norther at		10a. Street and Number				10f. Zip Cod			10g. Citizen of W	het Country?
	r hems 23s	6	5506 St. Helena		edent Ever in U	J.S. 13. V	212		? (Specify Yes or N	USA o- 14. Race	- American Indien,
	urs after al', or its	2	1 Never Married 2 Merried 3 XWidowed 4 Divorced	Armed Fo 1 Yes If Yes, Giv Year or D	rces? 2 No /8		Yes, specify C		? (Specify Yes or N Puerto Rican, etc.)	Specify:	k, White, etc.
IO.	2 EM 4	7010	15. Decedent's Ed (Specify only highest gra			16e. Deced	ent's Usuel Oc	cupetion ne during most of tired)	l working	16b. Kind of Bus	siness/Industry
2121		2	Elementery/Secondery (0-12) 6 yrs	College (1	-4or 5+)		ewife	tired)		OWN Ho	me
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yiar	ahould be and Mental and Mental and Mental and Mental and Mental		Guy William Ste	wart	196				e C. Arn		
-	I nd 2 should Health end Men I m 27 is merke r other traumetic		19e. Informent's Neme/Reletionship (1941) Mary Spidell D	Type, Print) aughte	r-In-				or Rural Route Num		State, Zip Code) d. 21222
200	Healt other	-	20e. Method of Disposition	augnice	20b.	Plece of Dispos	ition (Neme of		Dete		City or Town, Stete
altimore	8 = 5		1 ☐ Buriel 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify		Siaia	klawn			Nov 13 2000	Dundal	k, MD
Balt	Department Pa Department Important emy injury	2	24 Sonature of uneral pervice Ligery	5		Co	nnell				dalk, P.A.
		-	23a Part . Enter the disease, or composite the composite	olicetions that c	aused the dee	th. Do not ente	10 So	llers E dying, such es ca	rdiac or respiretory	 Dunda errest, 	1k, Md.21222
- 26	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	0		stive	1	1 ^	lue		Intervel Between Onset and Deeth
		5			to (or es e conseq	uence of):				
	hysician and the burist-transit	Yallill	Sequentially list conditions,	b	Due to (or as e conseq	uence of):				
8760,	ohysician and the burist-tran		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events	c	Due to /	or es e consequ	ience off:				
9 x	5 00		resulting In death) Lest	d	01000	or es e corisequ	ionoe oi).				
m.	for of		Pert II. Other significant conditions co	ontributing to de	eath but not re	sulting in the un	derlying cause	given in Pert I.	23b. Dte	d tobacco uss con	tributs to the cause of death?
s, P.O	5 60								10	Yes ZANO	3 ☐ Probably 4 ☐ Unknown
	peen shoul	200		SEX		24			24e. Wa	s an autopsy formed?	24b. Were autopsy findings evailable prior to completion of cause of death?
Re	The lay								10	Yes 200	1 ☐ Yes ≥ No
Vitai	ysician: The secretical director, pag	3	25. Wes case referred to medical examiner?	Magnitot: -				MINE TO STATE OF THE PARTY OF T	Deeth (Check only	one)	
of	A Sign	-	1 Yes 2 2000	Hospitet: 128		ER/Outpatien	JLI DOA		ing Home 5 Res	sidence 6 Othe	
lon	Attending Phir death. sctor: After the by the funeral		1 Vaturel 5 Pending 2 Accident investigation	(Mon	th, Dey Year)	Injury		njuryet Work? I□Yes 2□No		,	
ā	P P P P		3 Suicide 6 Could not be determined	286. PIECE	of Injury - At h	nome, ferm, stre	et, fectory, offi	ce		(Street and Numbe own, State)	er or Rurel Route Number,
	24 hours Funeral pletely filled			liner: On the be					plece, end due to the occurred et the time		nner as stated. and due to the cause(s)
			29b. Signature and title of cautility)	- 1	73.5	29c. Lic	ense number		29d. Dete signed	(Month, Dey, Year)
	2,0		1 How	WE			Do	0560	19	Novemb	er 9 2000
1	10	44	00. Name and address of person who i	Caus	e of deeth (Ite	m 23a) (Type, I	Print)	Mal	cel Con	1-0	
	State		31. Date filed (Month, Cary, Year)	32. R	egistrer's Sign	eture J	P	Turac	eel con	(8)	
	Registrar		14	2000	1 months	1	100	cks			

DHMH 16 Rev 6/95



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	ame (First, Middle, L							2. Date of De	Day	Year_	3. Tima of Death
ROBER	T J. SIMM	ONS						NOVEM	BER 9,3	2000	10:054
4a Facility Nam	e (If not institution, g	ive street and numb	per)				4b. City, Town, o	Location of Deal	h 4c. County	of Death	
	MARIS HOS						BALTIMO		N/		
5. Social Securit	6227	Sex 7. 1 ☑ M 2 ☐ F	Age (In yrs. I	ast birthdey Yrs.	Months	Days	If Under 24 Hr Houra Min	Month, Di	12, 1923	9. Birthple Counti VIRG	NIA
Usuel Residence	10b. County		10c, City	, Town or L	ocation					10	d. Inside City Lim
MD.	N/A			BALTI	MODE						1 X Yea 2 □
10e. Street and				DALII	10f. Zip	Code			10g. Citizen of V	Vhat Count	N?
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	ELLWOOD	AVENUE 12. Was Decede	ant Ever in 111	C 12		2122		Specify Ves or N	U.S.A	e - America	n Indian
11. Merital Stetu	s arried 2□ Married	Armed Force	es?	3. 13.	If Yes, ape	city Cub	an, Mexican, Pue	Specify Yea or Norto Rican, etc.)	Blac	k, Whita, e	
	d 4 Divorced	1 X Yes 2 If Yes, Give Year or Date	es: 1940-	1E	1 🗆 Yes	2 № No	Specify:		Specify		E
77,	15. Decedent's E		1940-	16a Dec	edent'a Uau	el Occur	pation		16b. Kind of Bu	WHIT usineas/Indi	
	pecify only highest g	rade completed)		(Giv	e kind of wo	ork done	during most of w	orking			
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	ne (First, Middle, Las	()	1	2.10			18. Mother's N	eme (First, Middle	, Meiden Sumen	10)	
GEORGE	SIMMONS						FAITH	COMPTON			
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	ANLEY SIMMONS/ SON 960 HOMBERG AVENUE, ESSEX, MARYLAND 21221 Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City of Date 20c. Loc										
1 Durial	2 Cremation 3		810		ematory or o			1/13/200	n PAITT	MADE	MARYLAND
	n 5 Other (Spec	-	UAN	-	I CEME		ess of Facility	1/13/200	DALII	MOKE,	MAKILAND
)	Tulisla Solvice Electron	33KA	Le	1		& ZE	ILER IN	C. FUNER		MARYL	AND 2122
23a. Pert1. Ent shock, or l	er the diseese, or con neart failure. List only	nplications that cau y one cause on eac	ised the dallsh ch line.	Do not er	nter the mod	de of dyir	ng, such es cardi	ac or respiratory	arrest,	1	Approximate Interval Between Onset and Deeth
Immediate Cau	se (Final		1	Mata	stut	10	Lung	(
disease or cond resulting in deel		a		r es a conse			- 2	- 1110			
			Due 10 (01	30 E CO1150	rquerice or).						
Sequentially list	conditions	b. ———	Due to for	as a conse	equence of):				The Table 1		
if any, leading to cause. Enter U	o immediate		(0		, , , , , , , , , , , , , , , , , , , ,						
Cause (Disease that initiated eve	or Injury	C	Due to for	es e conse	quence of):						
resulting in deat	h) Last		200 10 (0)	93 6 001130	iquerios or).						
		d									
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								1 🗆	Yea 20 No	10	Yes 20 No
25. Was case re exeminer?	ferred to medical							eeth (Check only			
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27. Manner of D	eath 5 Pending	28a. Date of (Month,	Injury Day Year)	28b. Time Injury	of H	28c. Inju Wo	ry at rk?	28d. Describe	how injury occur	red	

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After completely filled in by the fune Medical Certificatio

Baltimore, Maryland 21215-0020

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and menner stated. 29b. Signature and title of certifier

6 Could not be determined

29c. License number D40854 29d. Date signed (Month, Day, Year) 4/2000

28f. Location (Street and Number or Rural Route Number, City or Town, State)

21202

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ound Rischery, MD 301 St Phul

Bultmare

31. Date filed (Month, Day, Year) State Registrar

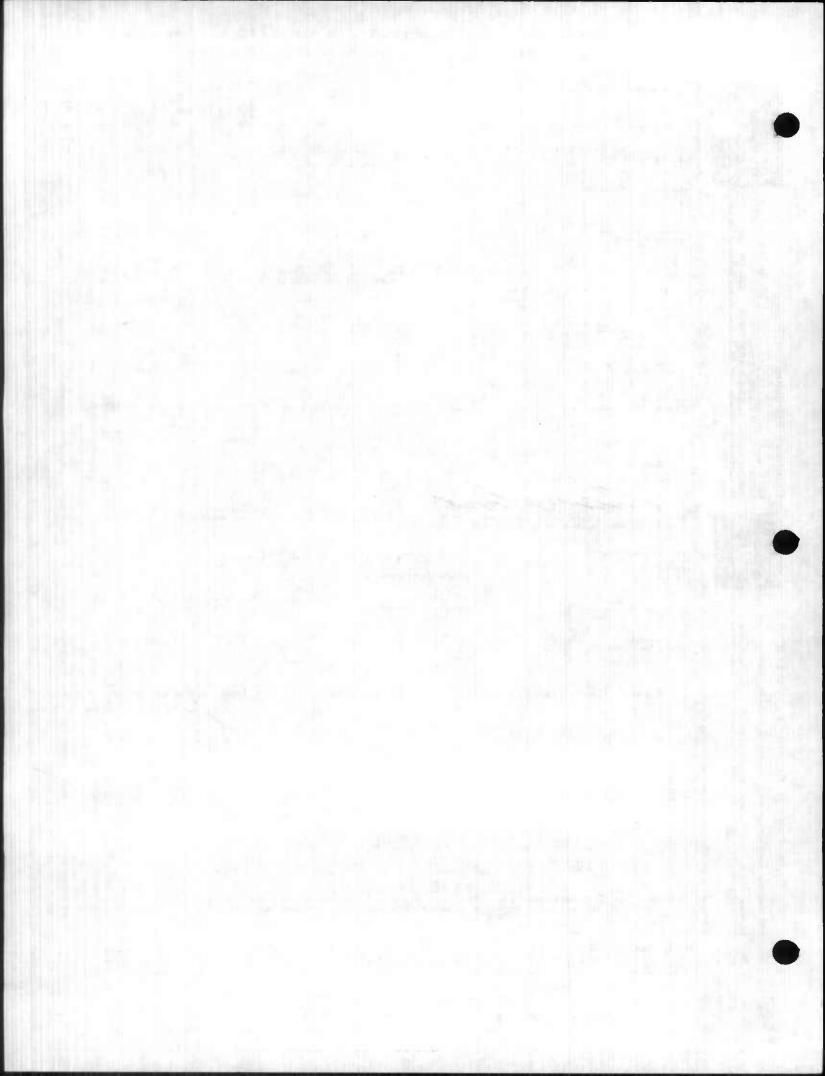
3 Suicide

4 Homicide

32. Registrar's Signature

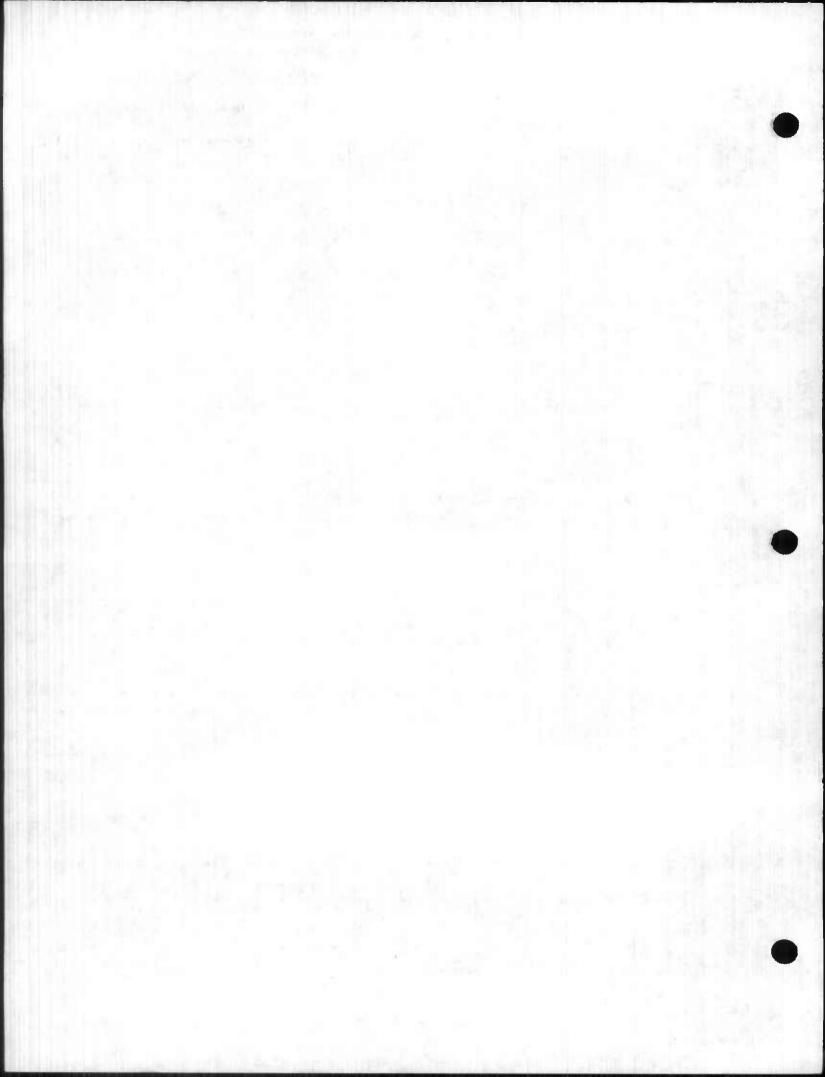


28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)



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Roy Taylor - husband 1838 Cedar Drive, Severn, Md. 21144	0	7,1000 0.000											
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Description Commerce Commerce Commerce Description Descripti	or other		uspand	20b. P			ive, seve			City or Town	State		
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T250 Washington Blvd., Elkridge, Md. 21075 25a. Part. Eight the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest. Approximate the mode of dying, such as cardiec or respiratory errest. Approximate Cause (Fine) disease or consolition resulting in death) Due to (or es a consequence of): Due to (or es a cons	-		-	Mea		7	1						
Immediate Cause (Final disease or condition resulting in death) Due to (or es a consequence of): Due to (or es e consequence of): Due to (o		1 Husm	fater	_									
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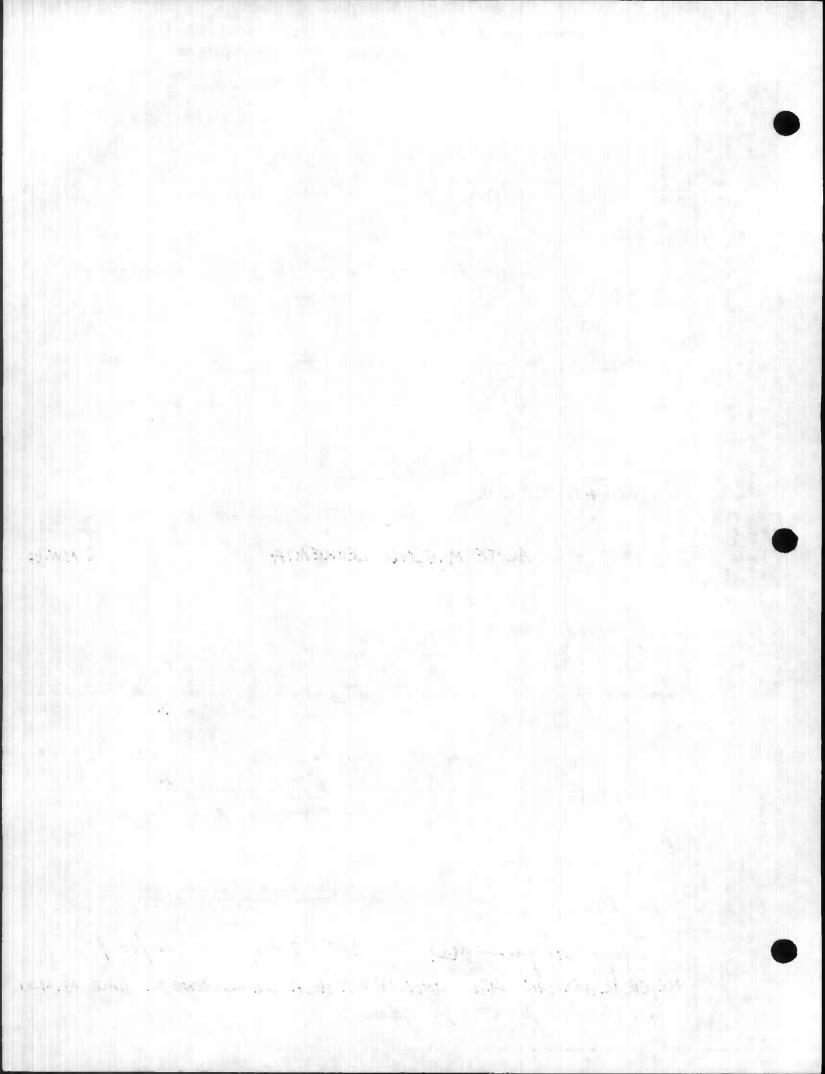
THYLOR, THEODORA M.



				State of N	Maryland		partment e <i>rtificate</i>					ene ()	0 3	6089	
	Dhamini		1. Decedent's Nama (First, Middle, Las)							2. Data of Deat Month	Day	Year	3. Time of Death	
	Physicia /Medic		Raymond	Tho			Thomps				NOV.	10,	2000	10:00am	
	Examin	er	4a Facility Nama (II not Institution, give		or)						cation of Death		nty of Death	1 1	
1			1804 Loreley Ros 5. Social Security Number 6. Se		Age (In yrs. las	t hirthdo	If Under	1 Yaar	Ld g	ewat	8. Data of Birth	An	ne Art		
Ų	Funeral Director		579-52-2006	M 20F	59	Yrs.	Months	Days	Hours	Min.	(Month, Day, OCT. 18		1 of	place (State or Foraign play)District Columbia	
	2 8 1		Usual Residence of Decedent 10a. Stata 10b. County		10c. City, 1	Town or	Location						1	0d. Inside City Limits	
	Mary End as	tor	Maryland Anne	Arundel			Edge	zate.	r					1 ☐ Yes 2X No	
	Dor 28	Directo	10e. Street and Number	arac a			101. Zip		1	41	10	g. Citizen o	of What Cour	ntry?	
	13 th w		1804 Loreley Road	dt					037				USA		
	No.	Funeral	11. Marital Status	12. Was Deceder Armed Forcas	s?	13	If Yes, speci	ent of Hi ify Cuba	ispanic Ori in, Mexicar	gin? (Spo n, Puerto	ecify Yas or No- Rican, etc.)		lace - Americ leck, Whita,		
020	er, or	by	1 Nevar Married 2 Married 3 Widowed 4 Divorced	I X Yes 2 If Yes, Give Year or Dates	, Vietna	m	1□ Yas 2	No	Specify:			Spec	oity: WI	nite	
2-0	72 ho	Completed	15. Decedent's Edu (Specify only highest grad		1	16a. Dec	edent's Usual	Occupa	ation	t of work	ina	6b. Kind of	Business/In	dustry	
7	Man .	mple	Elementery/Secondery (0-12)	College (1-4o	or 5+)	life	DO NOT us	e retired)						
7 0	ther the	S	12 17. Father's Name (First, Middle, Last)			-	Region	nal			(First, Middle, N	laiden Sum	Elect	tric	
au	o do	o Be	Unk.		Thomp	SOD			ro. wome		dred Per		arrioy		
37	M M M	F	19a. Informant's Name/Relationship (T	ype, Print)			iling Address	(Street	and Numbe		al Route Number,		vn, State, Ziç	Code)	
ž	27 in 27 in a tra		Kathleen Thompson	/wife		18	304 Lor	ele	y Roa	d	Edgewate	r, MD	2103	7	
ore	of to		20a. Method of Disposition	Samuel from Chat	Com	e of Dis	position (Nam	e ol har plac	e)				n - City or To		
Ě	Pag ment ant: t		1 Burial 2 To Cremation 3 4 Donation 5 Other (Special			o Cr	emator	У,	Inc.	1	1/11/00	Bal	timore	e. MD	
Sall	semili separt my in nose		21. Signisture of Funesal Stryica Lieup	Porala)		22. Name and			ty					
-	00240		Cremation Society of Maryland, Inc.												
			23a. Part1. Enter the disease, or comp shock, or heert failure. List only of	lications that caus ne ceuse on each	ed the death.	Do not e	nter the mode	of dyin	g, such as	cardiac	or respiratory arre	st,		Approximate Intervel Between Onset and Death	
	Physician /Medical		Immediate Cause (Final	1-15			2 1	*	- 4						
	Examiner		disease or condition resulting in death)	ACUTE				UK	EMI	H			1	2 MONTHS	
		Der			Due to (or a	s a cons	equenca or):						1		
	ate be executed hysician and the burial-transit	Examiner	Sequentially list conditions, if any, leeding to immediate	b	Due to (or as	s a cons	equenca of):						1		
20	s exe		if any, leeding to immediate cause. Enter Undarlying Cause (Disease or Injury												
à	physic s the b	edicai	that initiated events resulting in death) Last		Dua to (or as	a cons	equanca of):								
X	certificate ding physise as the	Me		d									i		
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9	that the deed by the detached	Physician/M	Part II. Other eignificant conditions co	ntributing to death	DUI NOT FESURIA	ng in the	underlying ca	iuse giv	en in Parti		1 Y			o the cause of death?	
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cords	w requires that been signed t should be det	Completed by									24a. Was a perform		av	ere eutopsy findings vailable prior to	
ie C	8 8 0	nple											of	empletion of cause death?	
	£ # #				JA SI		16-1				1 □ Y€	s 2× No	1 [Yas 2 No	
VIII	ician: Th certificate rector, pa	Be	25. Was case referred to medical axaminar?	Hospitel:				Oth	Or:		h (Check only on				
5	this aldi		1 Yes 25 No 27. Manner of Death	28a. Date of In	niury 28	VOutpati		Bc. Injun Wor	4LIN	ursing Ho	me 5 Reside			(y)	
SION	After Standard	ation	1 Natural 5 Panding 2 Accident investigation	(Month, E	Day Year)	Injury	М		k? Yes 2□	No					
IVIS	har das inector o by m	Certification	3 Suicide 6 Could not be determined	28e. Placa of i	injury - At home atc. (Specify)	e, ferm, s	street, factory	, office			28f. Location (St City or Town	reet and Nu	mber or Run	al Routa Number,	
2	Maria Della		20a Cartifier A Cartifician Ch.	nielen. To the bes	at of my knowle	den de	ath annumed s	t the tie	an data an	d atass	and due to the co	wanta) and		tatad	
	SZ4 TO	29a. Certifier (Check only one) 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, dete and pleca, and due to the cause(s) and manner and due to the cause(s) and due to th									e, and due t	o the cause(s)			
	Som de la	ž/	29b. Signature and title of certifier	,					e number			d. Date sig	ned (Month,	Day, Year)	
)	MIL	/	Mery K. H	equa	· M.V		- 1	10	82	46		11	/10	100	
-	1		30. Name and address of person who co		deeth (item 23	За) (Тур	e, Print)								
			MEYER R. HEYM	AN M.I) UI	VIV.	OF M). H	osp.	22.	S.GREG	VE ST.	: BA	TO MD. 21201	

DHMH 16 Rev 6/95

State Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Data of Death 1. Decedent's Nama (First, Middle, Last) 3. Tima of Death Dav Month Year **Physician** MARY TABELING 10:40 AM NOVEMBER 11, 2000 /Medical 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HARBOR HOSPITAL CENTER BALTIMORE N/A 8. Data of Birth (Month, Day, Year, If Under 1 Year | If Under 24 Hrs. | Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1□M 20F 72 Director 220-20-9280 June 12 1928 Maryland with the Maryland 10n. State 10b County 10c. City, Town or Location 10d. Inside City Limits Baltimore Md. Anne Arundel Co. 1 ☐ Yas 2 No Director 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 8 USA 21226 206 Greenland Beach Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? 14. Race · Amarican Indian, Black, White, etc. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 Yes 2 No
If Yes, Give A
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 8 Specify: white 1 ☐ Yes 2 ♥ No Specify: by 3℃ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) J. E. Smith Box Co. 9 Floor Lady 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Pages 1 and 2 should be fill ment of Heelih and Mental H ant. If them 27 is marked oth lury or other traumatic even Be Ruth Stricker Collins Elmer 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Daughter) Patricia Rush 18 Brookton Lane, Berlin, Md. 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata Data 1 XBurial 2 Cremation 3 Removal from Stata 11/16/2000 Baltimore, Md. Loudon Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Nama and Addrass of Facility McCully-Polyniak Funeral Home P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21225 Approximate Interval Batween Onset and Death Physician Immediata Cause (Final disease or condition resulting in death) /Medical VENTRICULAR FIBRILLATION 40 MINUTES Examiner Due to (or as a consequence of): Examiner HYPERKALEMIA 24 HOURS The law requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events partitions) Due to (or as a consequence of): physician the burial FAILURE Box 68760. CHRONIC RENAL Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): 8 987 Part II. Other algorificant conditions contributing to death but not resulting in the underlying causa given in Part I. P.O. 23h. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown ARTERY CORONARY DISEASE Records, à 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? HEART FAILURE CONGESTIVE DIABETES MELLITUS 1 Yes 2 No 1 ☐ Yes 2 No Division of Vital 25. Was case referred to medical examiner? or Attanding Physician: 8 26. Place of Death (Check only one) Hospital: 1) Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Rasidence 6 Othar (Specify) 1 Yes 2 No Certification: To this 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 XNatural 5 Pending To the Hospital or much withing 4 hours after death.
To the Juneral Director: Ah 1 TYes 2 □ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) neworla M.D. RES 001 NOVEMBER 11, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JASWINDER KHOSLA SOUTH HANDVER STREET, BALTIMORE 3001 31. Date filed (Month, Day, Year) NUV 1 4 2000 32. Registrar's Signatura State Denson Registrar

DHMH 16 Rev 6/95

LABELING

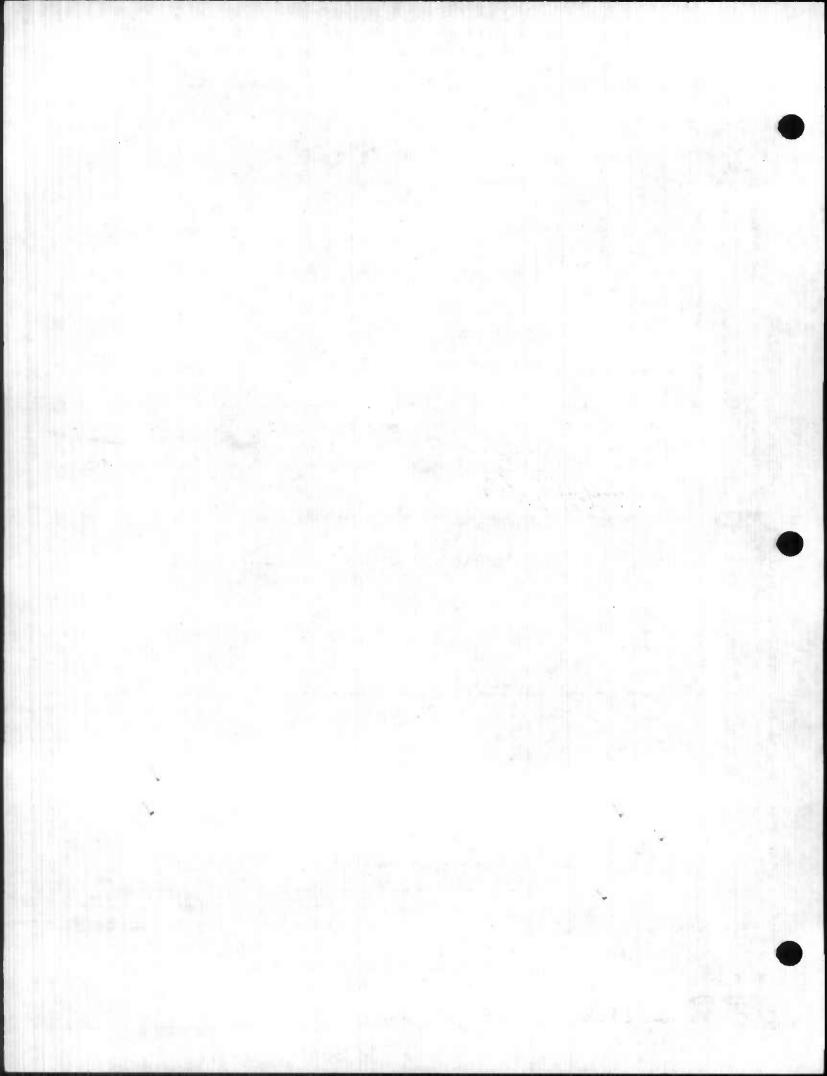
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State of Maryland / Department of Health and Mental Hygiene 0 0 3 6 0 9

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/	30. Nama and address of person who					503	573		11-9		
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DHMH 16 Rev 6/95

ORIGINAL



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Robert G. White 730,PM 2000 November 11 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Rosedale Baltimore Franklin Square Hospital Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 10 M 20 F 241-24-3287 77 Yrs. North Carolina Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore Directo Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 12720 Cunninghill Cove Road 238 21220 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1. 12 Yes 2 □ No If Yes, Give Yeer or Detes: WW II 14. Race - American Indien, Bteck, White, etc. 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married "natural", or Maryland 21215-0020 1 Yes 2 No Specify. White à 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Rusiness/Industry Etementery/Secondery (0-12) 12th Grade Cotlege (1-4or 5+) Navy Shipyard Engineer 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) should be and Mental Phillip Sulvia Hunter White 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) mit. Pages 1 and 2 st partment of Health and cortaint: If item 27 is n 12720 Cunninghill Cove Road, Baltimore, MD 21220 Mrs. Marie C. White (wife) 20b. Place of Disposition (Neme of cemetery, cremetery or other pleca) 20c. Location - City or Town, Stete 20a Method of Disposition Pages hant of h 1 Buriai 2 Cremation 3 Removat from State Oak Lawn Cemetery 11/16/00 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licenses 22. Name and Address of Facility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, 21236 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical 2 weeks cerebrovascular Accident **Examiner** Due to (or es a consequença of) Examiner cerebral Bleed Sequentietly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequença of): The law requires that the death certificate be execu P.O. Box 68760, attending physician for use as the buna Physician/Medical Due to (or as a consequence of): signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown Throm bocyto penia Idiopathic Division of Vital Records, PV 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed this certificate has 1 ☐ Yes 2 ☐ No 1 Yes 2 No Physician: Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2□ No 10 10 Impatient 2 ER/Outpetient 3 DOA Certification: 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred s or Attending P s after death.

I Director: After t od in by the funer. 1 Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicide To the Hospital of the Funeral Completely filled 1 Destifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

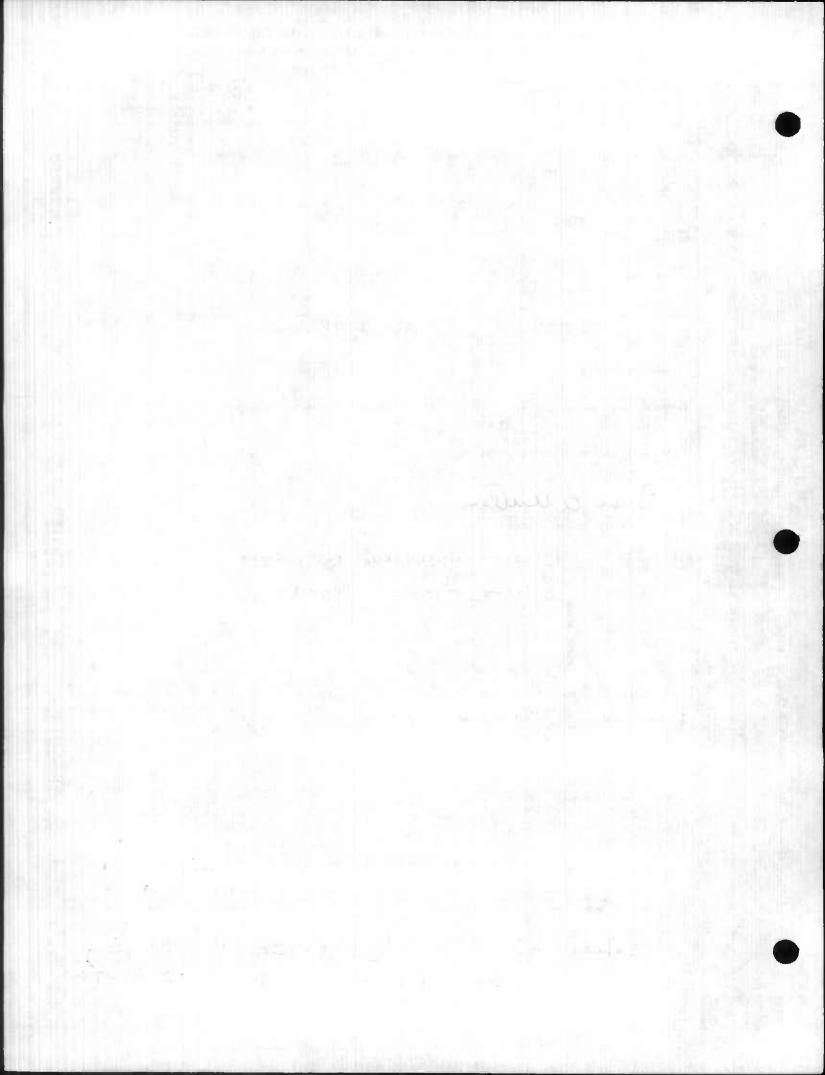
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29e. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture and title of certifier S. Kegura 53720 11/12/00 30. Nema and address of person who completed cause of death (Item 23a) (Type, Print)

S. Ragura, 2112 Belair Rd # 21047 am Fallston. #9 s. Roguray, 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture State oorks 2000 MOA

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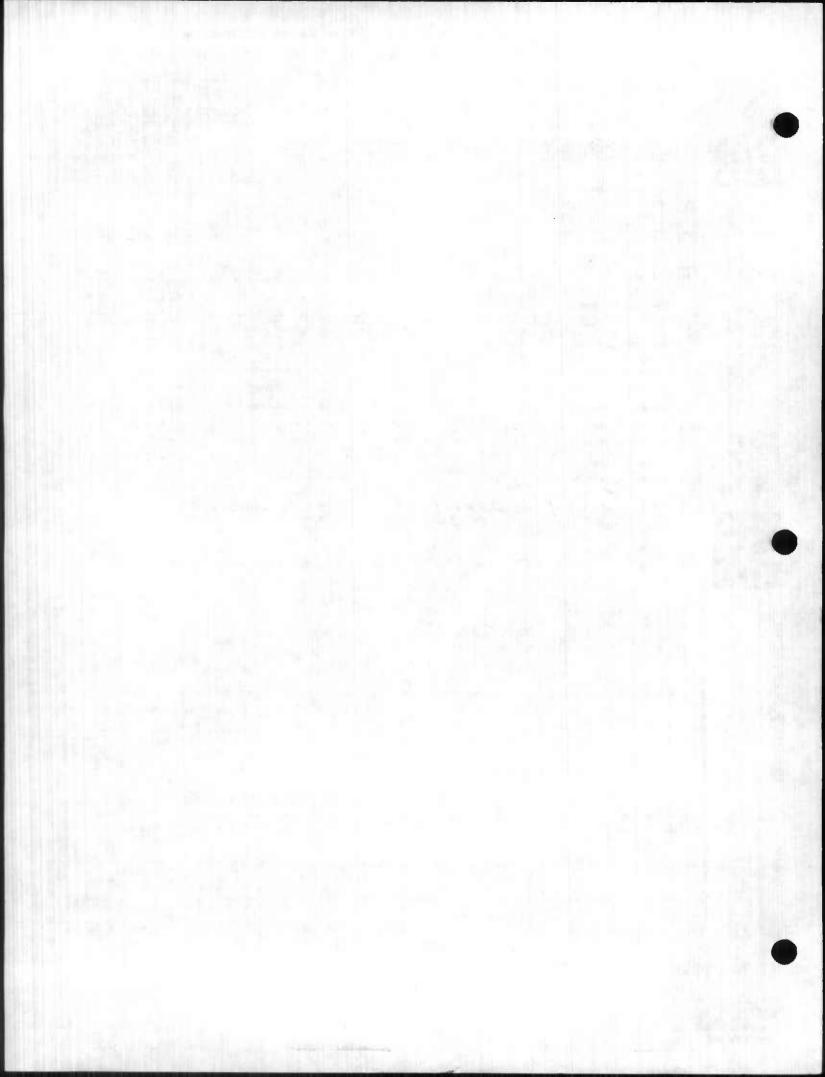


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State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Nashburn October 31, 2000 1:45 AM nne 0 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Silver Spring Montgomery Springbrook Nursing Center If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Jan 28, 1940 Birthplace (Stete or Foreign MD Country) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Hours 1□M 2\ F Months Deys 60 218-36-5291 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20905 USA 12325 New Hampshire Ave 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No !! Yes, Give Rece - American Indian, Black, White, etc. 11 Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No if Yes, apecify Cuben, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Merried 1 ☐ Yes 2 ☐ No Specify: white Specify: 34 Widowed 4 □ Divorced Yeer or Detes 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Induatry unk unk Elementery/Secondery (0-12) College (1-4or 5+) 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) unk unk 19e. Informent's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk 20e. Method of Disposition 20b. Plece of Disposition (Name of cametery, cremetory or other plece) Dete 20c. Location - City or Town, Steta Method of Disposition 1 Burial 2 Cremetion 3 Removed from State Charles (Specify) 11 State 21. Signature of Funerel Service Licensee Ronald S. Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director Dull 21201 Baltimore, MD . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, to rheart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Final week diseese or condition resulting in deeth) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of) Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed?

Physician /Medical Examiner

Department of Important: If any injury or once.

Physician

/Medical

Examiner

Funeral Director

Be Completed by

Funeral

Director

Peges 1 and 2 should be filled within 72 hours after death with the Maryland nent of Heelth and Mental Hygiene.
ant: If Hem 27 is marked other than "natural", or items 23s or 28s-f ahow ary or other traumatic event, or Medical Energy and that inotified as

Baltimore, Maryland 21215-0020

Physician/Medical Examiner The law requires that the deeth certificate be executed the burial-transit pue P.O. Box 68760, deteched for use as ate has been signed page 2 should be de Records, by Be Completed certificate or Attending Physician: funeral director, Certification: To After this death. within 24 hours after deat To the Funeral Director: filled in by

Division of Vital

Hospital

ag.

Pert II. Other signiffcant conditions contributing to death but not resulting in the underlying cause given in Pert i.

1 Yes 26. Place of Deeth (Check only one)

2 No 1 Yes

25. Was case referred to medical examiner? 1 Yes 2 No 27. Menner of Death 1 Netural
2 Accident

3 Suicide

4 | Homicide

5 Pending investigation

6 Could not be determined

28e. Dete of injury (Month, Day Year)

Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28b. Time of

Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work? 1 ☐ Yes 2 ☐ No

Other:

28d. Describe how injury occurred 28f. Location (Street end Number or Rural Route Number, City or Town, State)

28e. Plece of injury - At home, ferm, atreet, fectory, office building, etc. (Specify) Certifying Physician: To the bast of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner ateted. 29e. Certifier (Check only one)

29b. Signetyce and title of certifier WAS

29c. License number D 43 237

29d. Dete signed (Month, Day, Year) November 8, 2000

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Armotrons, M.D. 14201 Laurel PK. Dr. #102 Laurel, MD 20707 31. Date filed (Month, Dey, Year)

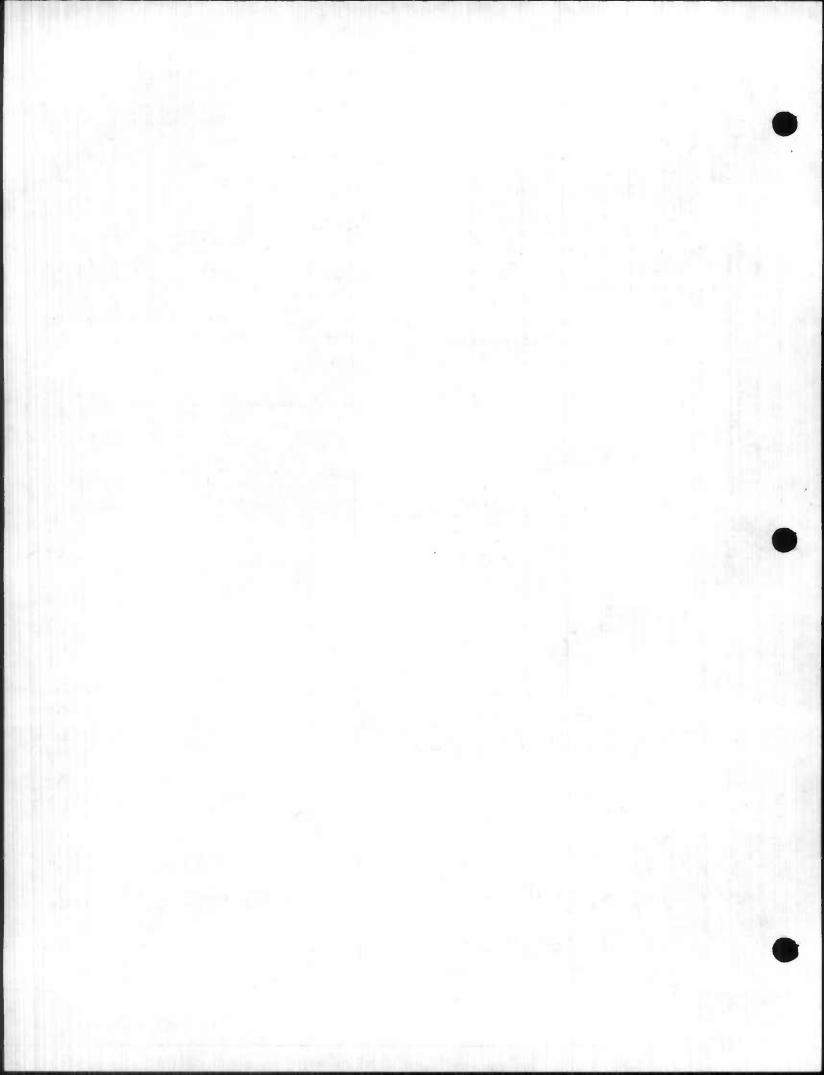
State Registrar

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32. Registrar's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36095 Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 10:50 AN **Physician** WoolforD November 11 4c. Codnty of Death /Medical 4e Fecility Neme (Innot institution, give street end number) 4b. City, Town, or Location of Death Examiner If Under 24 Hrs. 8. Dete of F N/A HEALTHC If Under 1 Year 8. Dete of Birth (Month, Day, Year) Apr. 25, 5. Social Security Number 9. Birthplace (State or Foreign Country) 6 Sax 7. Age (In yrs. last birthdey, **Funeral** Months Deys Hours 1 M 2 TF 71 Yrs. 215-24-7935 Director Usual Residence of Decedent r 28a-f ahow inctified at 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🖾 No Halethorpe Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? mast be n U.S.A. 1401 Woodside Ave. 21227 Funeral Herrs Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 72 hours after 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 8 21215-0020 White 1 Yes 2 No Specify: Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumerne) Peges 1 and 2 should be fill ment of Health and Mental Hant: If Nem 27 Is marked out Be Elizabeth Porter Oscar Charles Runkles 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Health & Health & Hem 27 lb Woodbine, MD. 21797 5601 Manor Dr. Kenneth Krouse, Son-in-Law 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burlal 2 Cremetion 3 Removel from Stete = 8 permit. Pege Department of Important: If any injury or once. 11-14-00 Baltimore, MD Loudon Park Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerei Service Ligensee 22. Name end Address of Fecility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete intervel Between Onset and Deeth Physician Immediete Cause (Final diseese or condition resulting in deeth) /Medical Examiner Due to (or as a consequence ot) Physician/Medical Examine Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Due to (or es e consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy parformed? Be Completed page 1 Yes 2 No 1 Yes 2 No

Registrar

25. Was case referred to medical

29b. Signeture and title of certifier

31. Date filed (Month, Day, Year)

MUITOMBO.

NOV 1 4 2000

5 Panding investigation

6 Could not be determined

30. Name and eddress of parson who completed cause of death (Item 23a) (Type, Print)

1 | Yes 2 No

27. Menner of Death

Neturel

2 Accident

3 Suicide

29e. Certifier

4 Homicide

10

Certification:

Medicai

After this

Director:

within 24 hours a To the Funeral C completely filled

death.

Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA

KAN KON BE

32. Registrer's Signeture

BRUN

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

MO

26. Place of Deeth (Check only one)

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the best of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date end plece, and due to the ceuse(s) end menner stated.

TZ

29c. License number

1 Yes 2 No

D46704

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

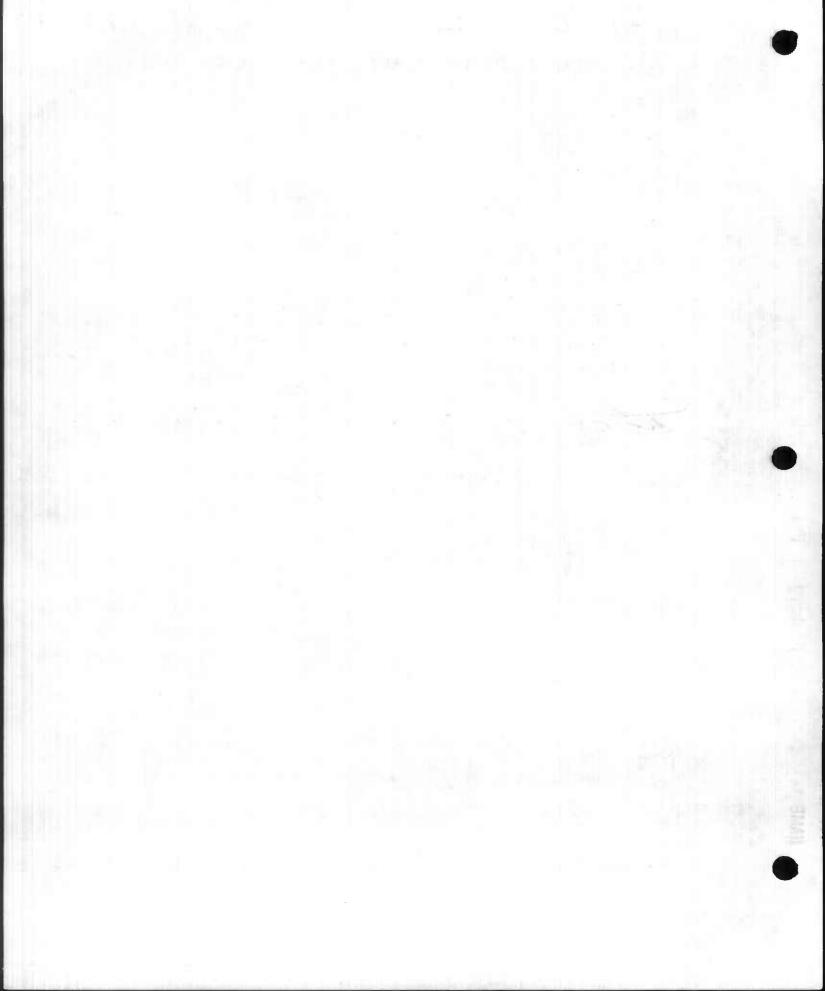
28d. Describe how injury occurred

281. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Nov

ACNES HOSPITAL BLT MA

29d. Dete signed (Month, Dev. Year)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'e Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Year **Physician** Bonnie Jean Whittaker 2000 04 45 AM NOV /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4109 Oak Road Baltimore Hglnds. Baltimore 5. Social Security Number 7. Age (In vrs. last hirthday) If Under 1 Year If Under 24 Hrs. Birthplaca (Stata or Foraign Country) 8. Data of Birth (Month, Day, Year) **Funeral** Days Hours 1□M 2/2 F Months 61 Director 230-48-0448 Virginia Usual Residence of Deceden the Maryland 10s. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 2♥ No Director 286. Md. Baltimore Baltimore Highlands 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 8 na 23a or must be 4109 Oak Road 21227 USA Funeral 14. Raca - American Indian, Black, Whita, atc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11 Marital Status filed within 72 hours after 1 Never Married 2 Married "natural", or b adical Examin Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ② No Specify: Specify: white þ 3 ☑ Widowed 4 ☐ Divorced Al Hygiens d other than "nature." the Medical F Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: If then 27 is marked other
any Injury or other trausment. 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumama) Be Payton McPeak Grace Rogers 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rodney Whittaker - son 1614 Manning Road, Glen Burnie, Md. 21061 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetary, crematory or other place) Data 20c. Location - City or Town, Stata 11/11/00 1 DBurial 2 Cremation 3 Removal from State Meadowridge Memorial Pk. 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, Md. 22. Nema and Address of Facility 21. Signature of Funeral Service Licenses Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. medical disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, and failure. List only one cause on each line. 21075 Approximate Interval Batween Onset and Daath **Physician** non small cell lung cancer /Medical Immediata Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner sician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Box 68760. Physician/Medical Due to (or as a consequence of): for use signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did lobacco use contribute to the cause of deeth? P.O. 10 100 2 No 3 Probably 4 Unknown Records. à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed page 2 4 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Assidence 6 Other (Specify) 1 Yes 2 No Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA the funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 1 1 Natural 5 Pending investigation 1 Yas 2 No 24 hours after death. 2 Accident 6 Could not be 3∏ Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital it Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mennar as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29d. Dala signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 022782 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) X 3001 South Hanower Street Battimers, Meryland 21225 rkman mo 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State

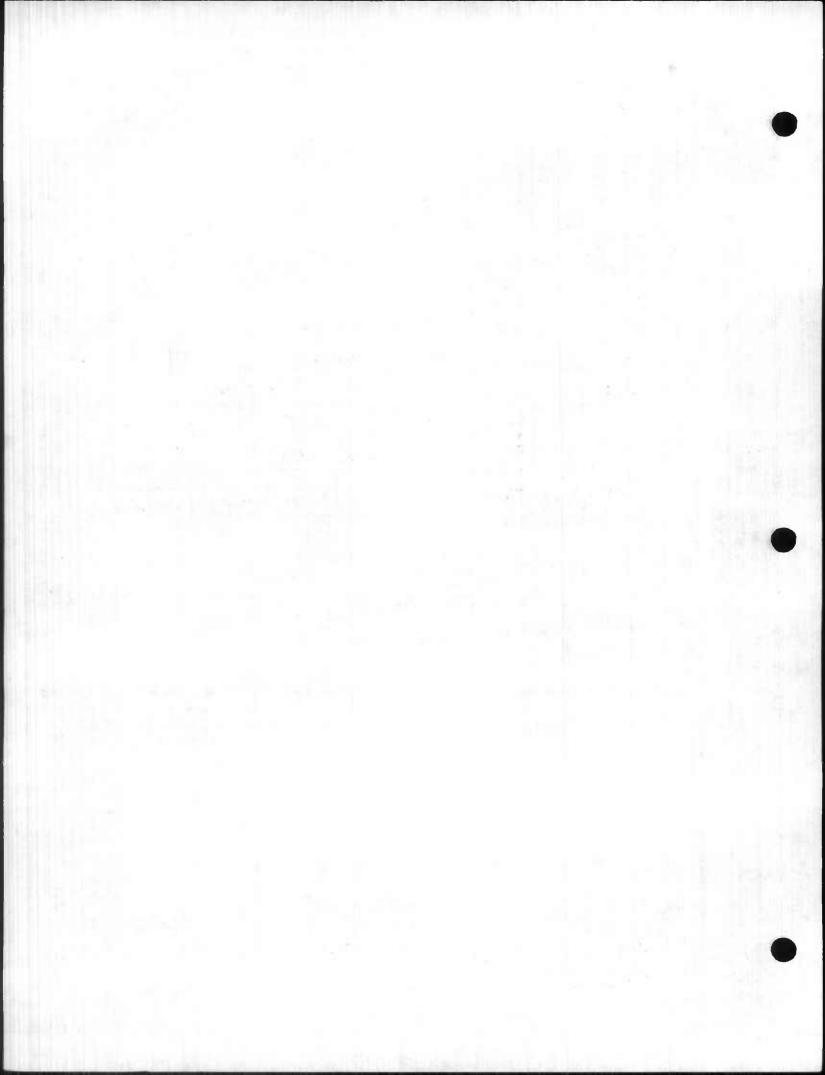
DHMH 16 Rev 6/95

Registrar

NOV

2000

Darks



State of Maryland / Department of Health and Mental Hygiene *Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Yeer Month **Physician** DOROTHY WIEST NOV 06 0745 2000 /Medical 4s Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD COUNTY GENERAL HOSPITAL HOWARD COLUMBIA If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. last birthdey) If Under 1 Yeer Months Days Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funerat** 1□ M 25 F 82 212-16-0120 Director AUG. 23, 1918 Maryland Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. Stale 28a-f show Baltimore MD Catonsville 1 Yes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 303 Maiden Choice Lane Herra 23a 21228 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Merital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0020 'natural', or 1 Yes 2 No Specify: Specify. white þ 3 Widowed Divorced Completed 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Social Security Government 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 88 should be a marked Cecil Earl Hood Rosa Mae Auer 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) nit. Pages 1 and 2 st artment of Health an ortant: If Ihem 27 is r ä Judy Minton - daughter 6330 Old Washington Rd., Elkridge, Md. 21075 Baltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 11/11/00 1 Burial 2 Cremation 3 Removal from State Baltimore Washington Crm. 4 ☐ Donation 5 ☐ Other (Specify) Laurel, Md. 22. Name and Address of Facility 21. Signature of Funeral Service License Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. elevs 7250 Washington Blvd., Elkridge, Md. 21075 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** SEVERAL Immediate Cause (Final diaeaae or condition resulting in death) /Medical · ARDS DAYS Examiner Due to (or as a consequence of): Examiner PNEUMONIA LWEEK attending physician and for use as the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): 6 WEEKS 68760 LUNG CANCER Physician/Medical that initiated events resulting in deeth) Last Due to (or es a consequence of): Box P.O. Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 94 yd bengis DIABETES MELLITUS Records. p 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yea 2 No To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. fnjury at Work? To the Hospital or Attending within 24 hours after death. To the Funeral Director; After 1 Matural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. edicai 29e. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier D0018317 NOV 06 1 21 mD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RERNARD P. FARRELL MD 11055 LITTLE PATULENT PKWY, COLUMBIA, MD 21044

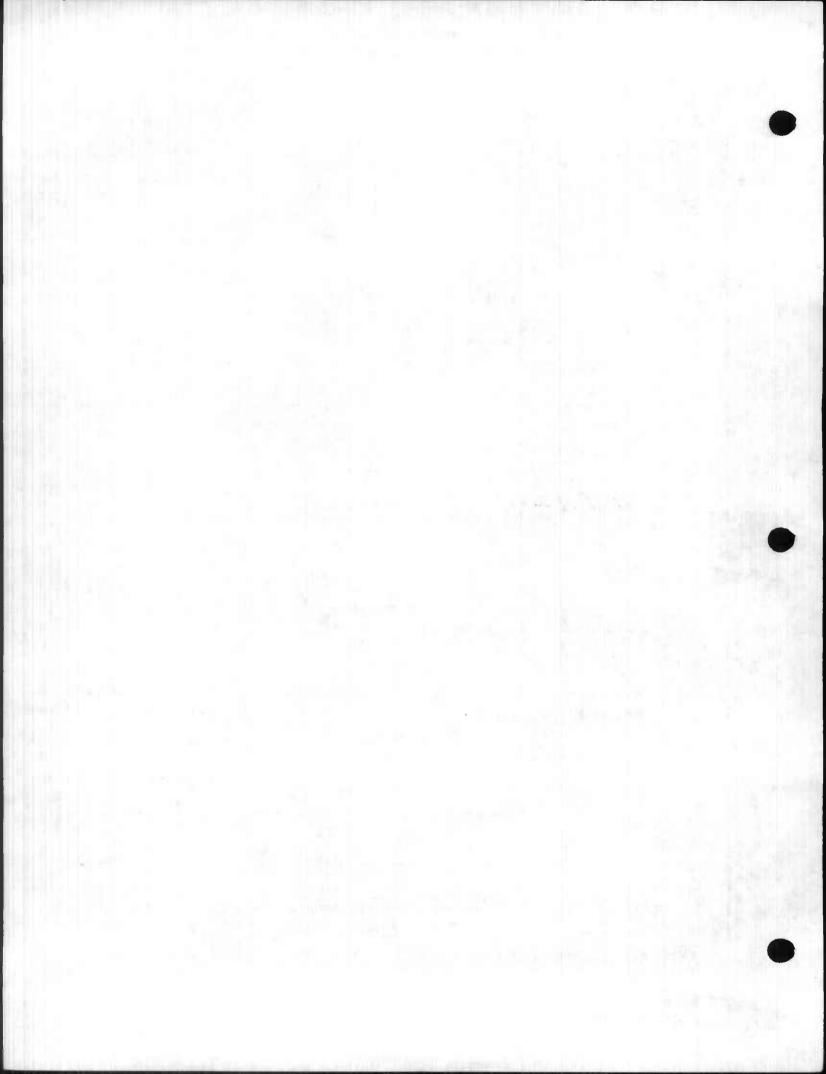
Registrar **DHMH 16 Rev 6/95**

State

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

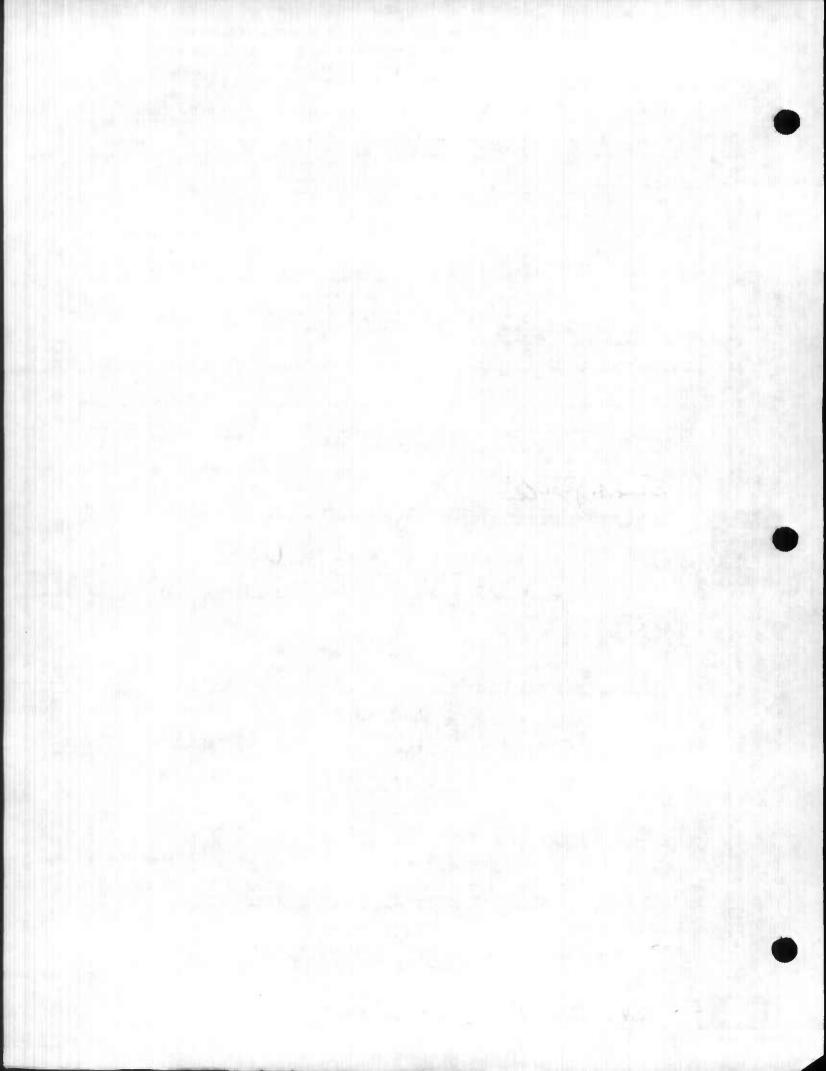


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Margaret Walk
4a Facility Nama (Most institution, give street and number) Walker November 2:15 PM 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Horpita NIA Good Jameritan If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign **Funeral** 1□ M 2 F Months 265-22-3690 Yrs. Director 1921 Maryland Usual Rasidence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic avant, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Baltimore 10f. Zip Coda 10e. Street and Number 10g. Citizen of What Country? Name 23a or 21239 1317 Heather Hill Road USA Funeral 12. Was Decedent Evar in U,S.
Amed Forces?
1 ∑Yas 2 □ No
If Yas, Giva
Yaar or Datas: WWII Was Decedant of Hispanic Origin? (Specify Yas or No. If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, White, atc. 1 Never Married 2 Merried natural, or Baltimore, Maryland 21215-0020 1 Yas 2 No Specify b 3 XWidowed 4 ☐ Divorced White Completed permit. Pages 1 and 2 should be filled within 72.1 Department of Health and Mental Phygiene. Important: if item 27 is marked other than "naturally or other traumatic avant, mail." 15. Decedant's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Homemaker Own Home 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) John Pelham Clarke Florence McNish-Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 1317 Heather Hill Road Baltimore, MD 21239
of Disposition (Name of Dela 20c. Location City or Town, Stata Matthew E. Walker/Son 20b. Place of Disposition (Name of cematary, cramatory or other plece) 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Crametion 3 ☐ Removel from Steta 4 Donation 5 Othar (Specify) Metro Crematory Inc. Baltimore, MD 11-14-00 22. Nama and Addrass of Facility
Cremation Society of MD, Inc. Fdward A. egorchia 299 Frederick Road Baltimore, MD 21228 Approximata Interval Batween Onsat and Daath 23a. Part1. Enter the disease or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Physician Immediata Causa (Final disaasa or condition rasulting in death) /Medical Examiner Physician/Medical Examiner Myocardial certificate be executed Sequentially list conditions, if any, leading to Immadiata cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last attending physician and for use as the bunal-tren 68760 Dua to (or as a consequence of) P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Ves 2 No 3 Probably 4 Unknown Resuscitation from Sudden Death Records, Completed by 24b. Ware autopsy findings evailable prior to completion of cause of death? 24a. Wes an autopsy performed? ANOXIC Eucepholopathy 1 Yas 2 No 1 ☐ Yes 2 ☐ No of Vital Be 25. Was case referred to medical examiner? 26. Placa of Deeth (Check only one) Hospital: 12 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 2 1 Yas 2 No To the Hospital or Attanding Phytibin 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral edical Certification: 27. Menner of Death 28c. Injury at Work? 28d. Dascribe how Injury occurred Division Netural 2 Accident 5 Panding invastigation 1 Yas 2 No 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At homa, ferm, streat, factory, office building, atc. (Specify) 4 Homicide 29a. Cartifier 1x Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) end manner stated. (Check only one) 29d. Data signad (Month, Day, Year) 29b. Signatura end title of contilier 29c. Licansa number November 268126N 30. Name and eddrass of person who completed causa of death (Item 23a) (Type, Print) RAVEN BLUD, GOOD SAM 31. Data filed (Month, Day, Year) NOV 1 4 2000 NOV Registrar

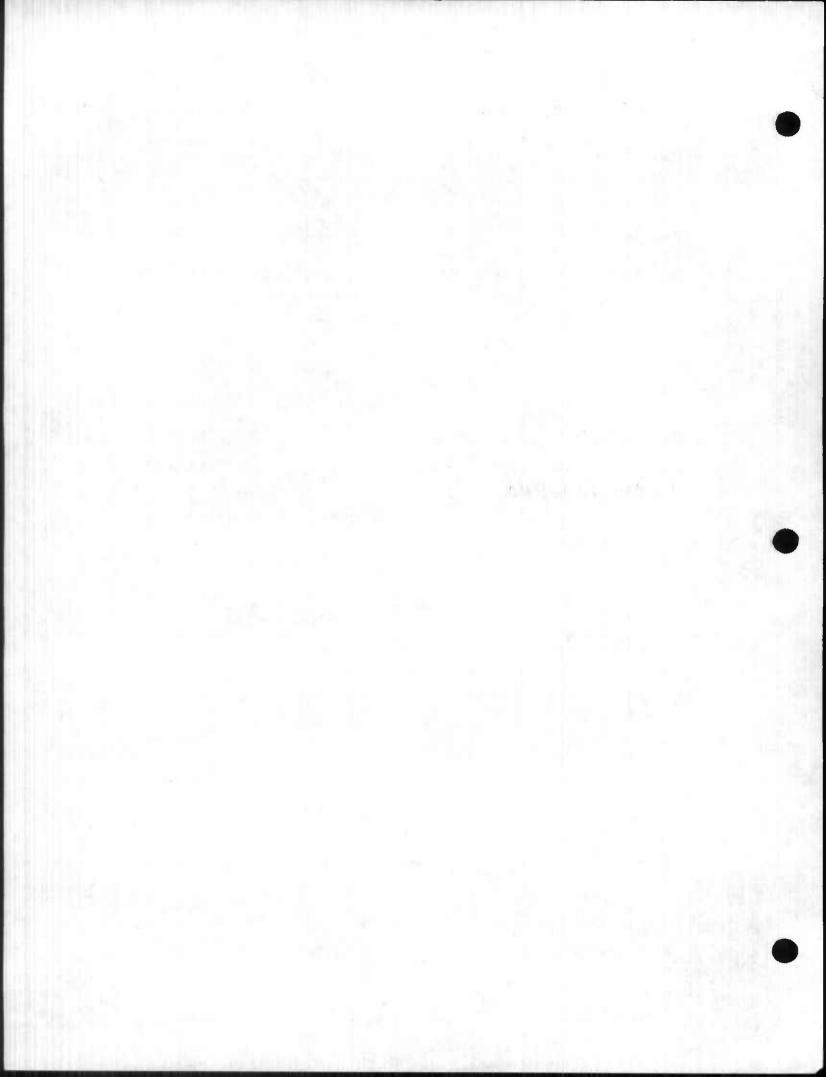
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State of

f Maryland / Department of Health and Me	ntal Hygiene	3609
Certificate of Death	See No.	000

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## Facility Name of Processing and Season Courty Entertail Display County C		Phillip Shery	wood Weems Sr							19.32 PM
Total Section Processor						4b. City, Town, o				19.32 FM
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Twen sharing 2 Marie 2	o Maryl last sho difed a	Maryland N/A								- N
The control of the	or 2	10e. Street and Number			10f. Zip Code		10	g. Citizen of V	Whet Coun	try?
Twenty Name	w 23s	1616 DeLano Court			21217			USA		
Signating Prival grades completed Signature Sign	ter dine	11. Marital Stetus 1 Never Married 2 Married	12. Was Decedent Ever in U,S Armed Forcas? 1 ☐ Yas 2 ☐ No If Yes, Give	lf Y	Yes, specify Cub	en, Mexican, Pue	(Specify Yes or No- erto Rican, atc.)	Bled	ck, White, o	etc.
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Physician (Modical Examiner) 209 Frederick Road Baltimore, MD 21228 210 Physician (Modical Examiner) 211 Page 11 First the diseases, or complete instance and each instance of death and of diving, such as cardiac or respiratory arrest, interest Barwaco (Crise and Baetin) 211 Page 12 Page 13 Page 14	82=8	1 ☐ Buriel 2 ☐ Cremetion 3 ☐	Hemovel from State				11 1/ 00			1.00
Physician (Modical Examiner) 209 Frederick Road Baltimore, MD 21228 210 Physician (Modical Examiner) 211 Page 11 First the diseases, or complete instance and each instance of death and of diving, such as cardiac or respiratory arrest, interest Barwaco (Crise and Baetin) 211 Page 12 Page 13 Page 14	g and the	2 10	/) Met				1		altimo	ore, MD
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Physician (Medical Examiner) Part Color Course Final disease or condition, resulting in death) Due to (or as a consequence of):		23a. Part1. Enter the diseese, or comp	olications that caused the deeth							Approximete
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29a. Certifier (Check this and manner as stated.) 29b. Signature and title of certifier (Section 2) 29b. Signature and title of certifier (Month, Dey, Year) 31. Date filed (Month, Dey, Year) 32. Registrer's Signature 29a. Certifier (Check this and manner as stated.) 29b. Signature and title of certifier (Check this and manner steted.) 29c. License number (D. M. E. November 11, 2000) 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201	or Attendation of Attendation of Attendation of Attendation of the Control of the Control of the Control of Attendation of Att	3 Suicide 6 Could not be	28e. Plece of Injury - At hor	me, ferm, stree					ber or Rure	al Route Number,
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Juffer Cock, WD 111 Penn Street, Baltimore, Maryland 21201	1	Color	- Marie		0.	C.M.E.		Novembe	er 11	, 2000
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	State	31. Date filed (Month, Dey, Year)	32. Registrer's Signat	luse						



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ^{Day}2000 NOV. 13, **Physician** 7:00pm Carolyn Sue Wilder /Medical 4c. County of Deeth 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner 1612 Concordia Drive Pasadena Anne Arundel If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) APR. 15, 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 M 2 KF Months Hours Maryland 69 Yrs 217-28-7769 1931 Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or hama 23s or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Anne Arundel Pasadena 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 21122 1612 Concordia Drive USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Merital Status flied within 72 hours after 1 ☐ Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: by 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondery (0-12) Registered Nurse Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) peemil. Pages 1 and 2 should be fitted.
Department of Health and Mental Hy important: If them 27 is merised oth any Injury or other treumstic even state. Unk. Malsberry Unk. 19a. informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah S. Rowland-Miller/daughter 305 SW Tulip Blvd. Port St. Lucie, FL 34953 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 ☐ Buriel 2 M Cremation 3 ☐ Removel from State Metro Crematory, Inc. 11/14/00 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22 Neme and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228 Dawn F. McDonald 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or es a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yee 2 No 3 Probably 4 Unknown p 24b. Were autopsy findings evailable prior to completion of cause of death? Completed page 2 should 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No this certificate or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 25 No 28c. injury et Work? 28d. Describe how injury occurred 27. Mapner of Death 28b. Time of Certification: After 1 Neturel 5 Pending investigation after death.

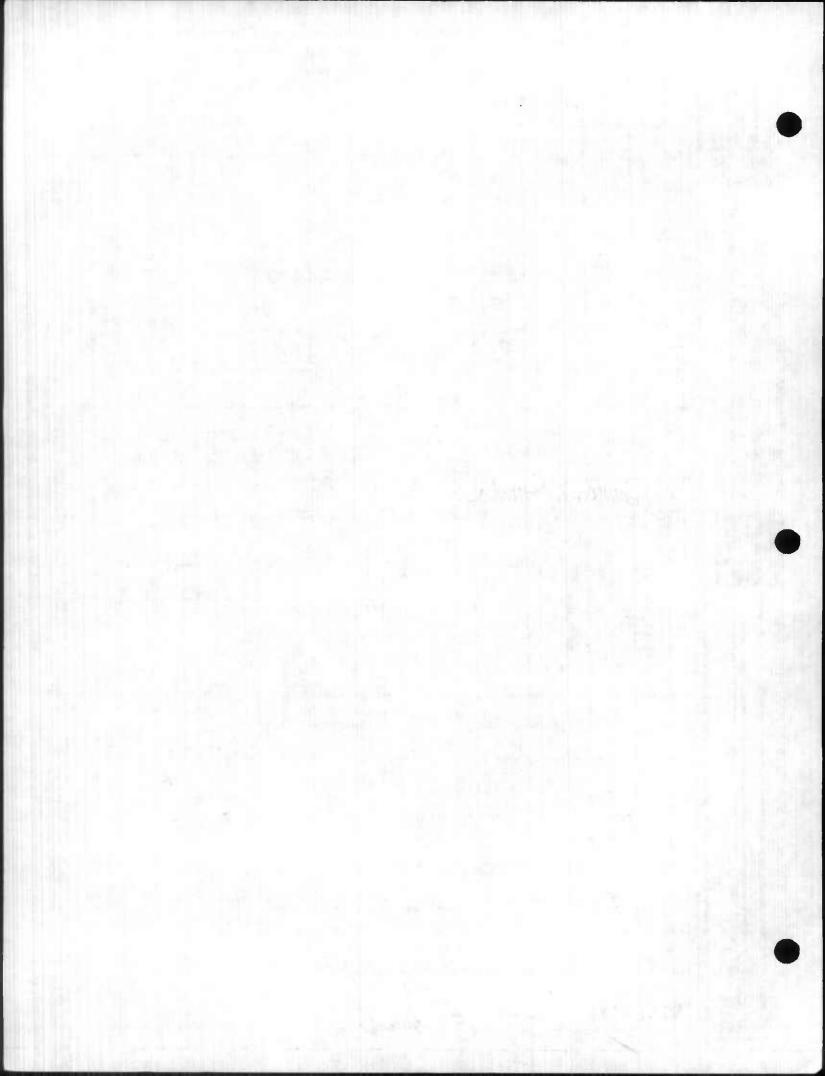
Director: Aft
d in by the fur 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide To the Hospital or within 24 hours after To the Funeral Discompletely filled in Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) 29a. Certifier edical end menner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Veder m 0 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) 200PE MD thervi

DHMH 16 Rev 6/95

State Registrar V 1 4 2000

32. Registrer's Signetura



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month **Physician** NOVEMBER 10 2000 1:30 AM ARNOLD L. WENGER, SR. /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL CO. PASADENA 8256 BALTIMORE ANNAPOLIS BLVD. If Under 1 Yeer | If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Dey, Year) **Funeral** Months M 20 F Deys Hours 67 Aug.12 1933 Director 218-28-4476 West Virginia **Usual Residence of Decedent** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Anne Arundel Co. Pasadena 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r 8256 Baltimore Annapolis Blvd. 21122 USA Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

XYYes 2 No Korea
If Yes, Give
Yeer or Detes: "natural", or items ofical Examiner ma Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Meritel Status Black, White, etc. 1 Never Married 2 Merried Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Goddard Elementary/Secondery (0-12) College (1-4or 5+) Hygiene Space Center 12 Financial Analyst +4 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Pages 1 and 2 should be fittered of Health and Mental Health and Mental Health and Mental Health are confer traumatic evensions of the pages of the Be Virgil F. Christine S. Wenger Wenger 19e. Informent's Neme/Retationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8256 Baltimore Annapolis Blvd. Pasadena, Md. 21122 Barbara A. Wenger (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Buriel 2 Cremation 3 Removel from State Glen Haven Memorial Park 11/13/2000 Glen Burnie, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility McCully-Polyniak Funeral Home P.A. Alline 3204 Mountain Road, Pasadena, Md. 21122 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximate Intervat Betw Onset and Death **Physician** tmmediate Cause (Final disease or condition resulting in death) /Medical carcinona of creter Transitiona Examiner Due to (or as a consequence ot) Examine certificate be executed physician and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or es e consequence of): USB AS 1 signed by the a P.0. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Wera autopsy findings available prior to completion of cause of death? should Completed 24a. Wes an autopsy performed? page 2 s certificate has 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 10 this 28a. Date of tnjury (Month, Dey Year) To the Hospital or Attending PI within 24-hours, after death.

Taghe Funeral Director: After the completiely littled in by the funeral 28b. Time of Injury 28c. Injury at Work? 27. Manngrot Death 28d. Describe how injury occurred Certification: 1 DNetural 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Médical 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number 022782 m 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Berkner

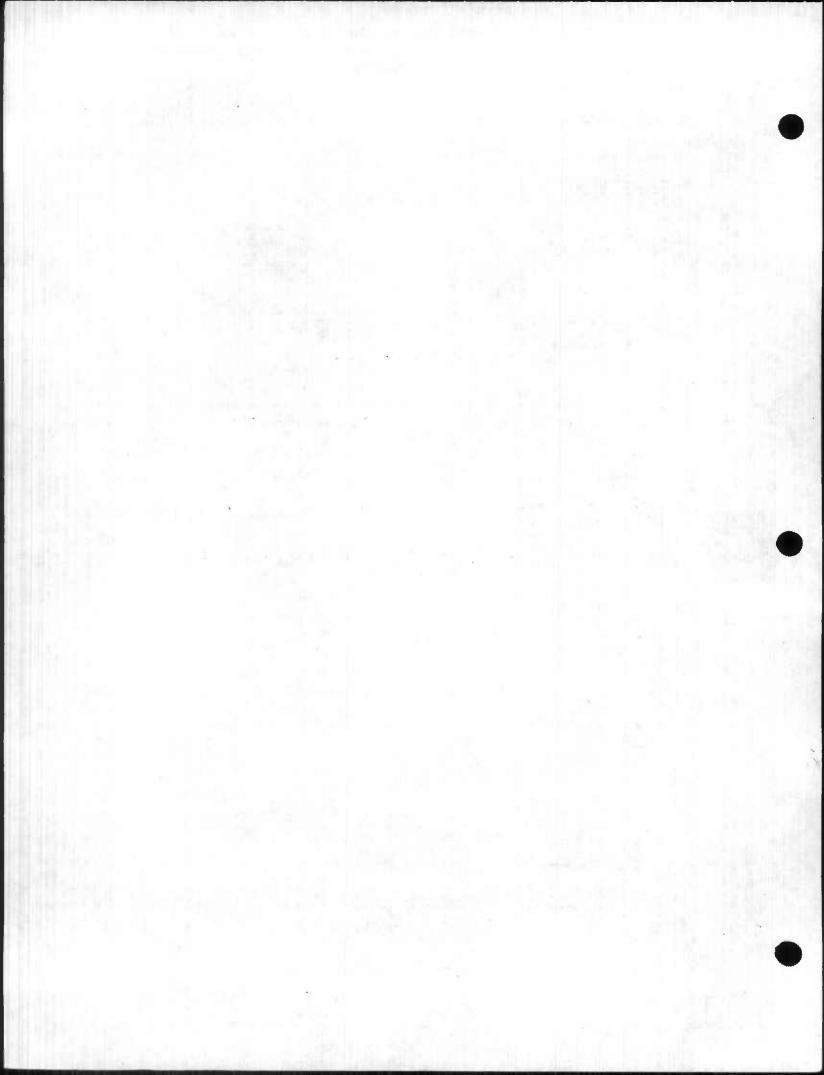
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32. Registrar's Signature

Harays Street, Baltmore Mayland 21225



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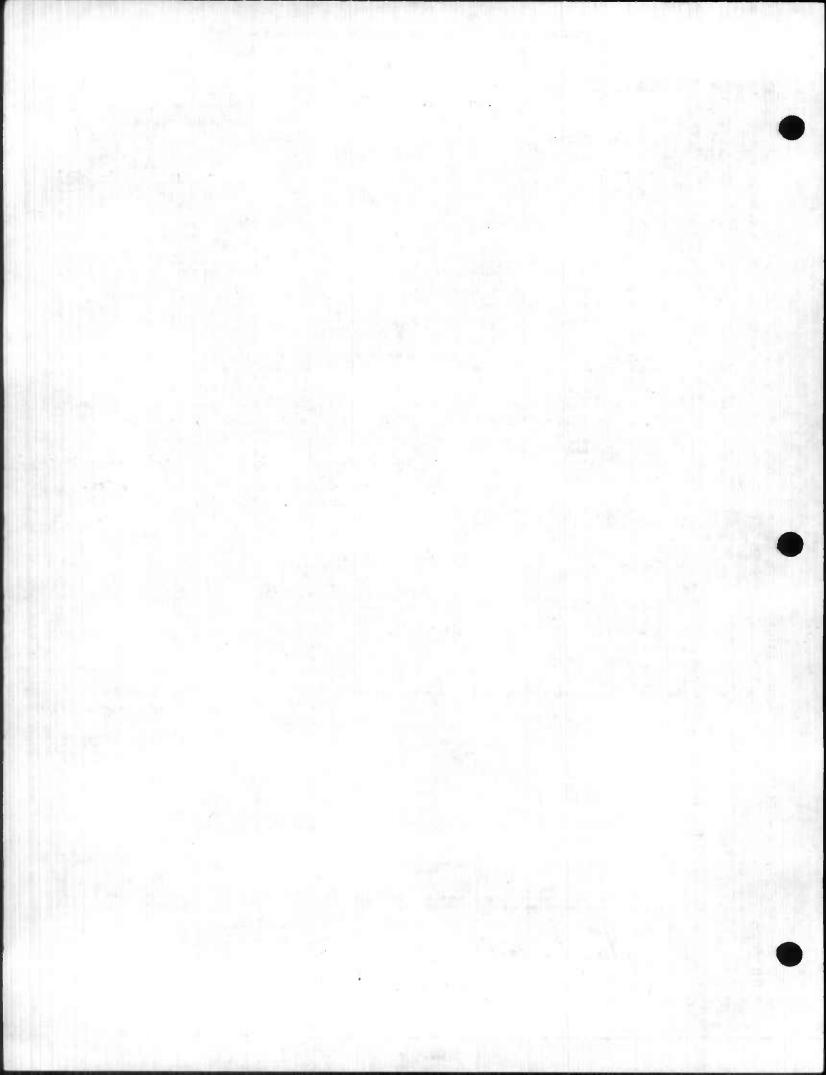
Registrar

DHMH 16 Rev 6/95

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32. Registrer's Signature

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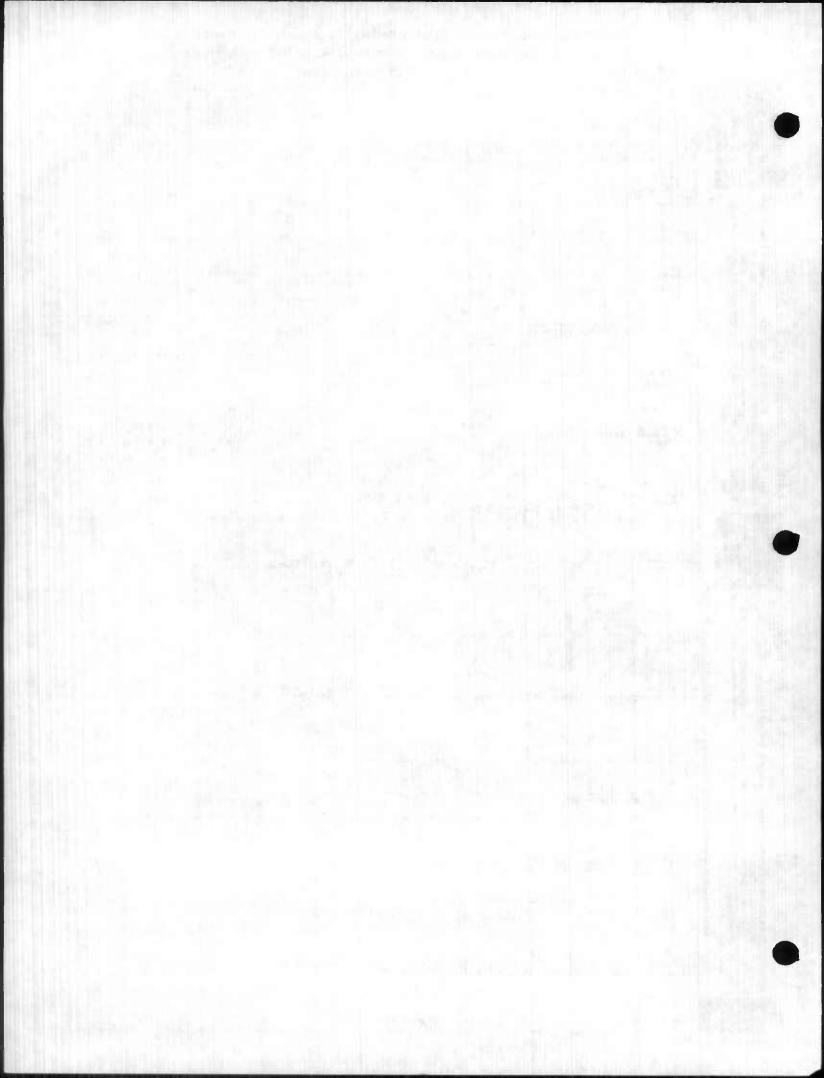


Charles Robert Wehnert 3rd Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

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State of Maryland / Department of Health and Mental Hygiene	0	l.
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	PAMELA JEAN WEHN	ERT (WIFE	3:	25 NAT	URE V	WALK LANE	, PASADI	ENA, MAR	RYLANI	21122
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9000	21. Signature of Funaral Semico Lice	0000				ss of Facility SI				
cian	23a. Pert1. Eril - fia disaasa, or com shock, o - I failura. List only	one cause on each line	ne daath. Do not	anter the mo	de of dyln	ng, such as cerdiec	or respiretory ar	rest,		Approximate Intarval Batween Onset and Deeth
dical niner	Immedieta Causa (Final disaasa or condition resulting in deeth)	å	Multi- ua to (or es e con	le sequence of	inju	acies			1	
edical Examiner	Sequentially list conditions, if any, laading to immadiata ceuse. Entar Undarlying	b	ua to (or as a cor	sequance of):					
- W	Causa (Diseasa or Injury that initiated evants rasulting in death) Last	d.	ua to (or as a con	sequance of	:					
clan	Bad IA Cabarata Managarata	and the sales of the sales by a			and the same of		anh Bida			Ab4 d
/ Physician/M	Part It. Other significant conditions of	contributing to death but	not resulting in tr	e underlying	ceuse giv	en in Paπ I.		es 2 No		the cause of death?
Completed by P						5171	24a. Was perfor		con	ere autopsy findings allable prior to applation of ceusa death?
ro Be Com							1,20 Y	es 2 No	1,0	(Yas 2□ No
BeC	25. Was casa retarred to medice!					26. Placa of Dea	th (Check only o	na)		
ToB	examinar? 1)X) Yes 2□ No	Hospital:	2 □ ER/Outpa	itient 3 0	OA Oth	nar: 4□ Nursing H			nar (Specify) Scene
	27. Mennar of Death	28a. Data of Injury (Month, Day)	28b. Tim	a of	28c. Injur Wor		28d. Describe t	pw injury occur	red Sub	ject was
ation	1 □ Netural 5 □ Panding 2 ★ Accidant investigation	11-7-200	0 123	5 PM		Yas 2 No	in	calli	sion	
Certification:	3 Suicida 6 Could not b	e One Steen of Initia	y - At home, ferm	, street, facto	ry, office		28f. Location (S City or Tow	traet and Number, State) Z-7.	Der or Rura	PRoute 29
Cer			treet							ryland
edical Ceri	29a. Certifier 1 Certifying Pt (Check only one)	nysicien: To the best of animer: On the bests of a and menner state	my knowledge, d xeminetion and/o	eath occurre r invastigetio	d at the tin n, in my o	me, date and place pinion, daath occu	, and dua to tha	ausa(s) and me	enner as si	ated.
/8	29b. Signeture end titte of certifier	. 1	/	2	c. Licans	a number		29d. Dete signe	d (Month, I	Day, Year)
	Mysy	1 VL	del	MA	0.	.C.M.E.		Novem	mber 8	3, 2000
()	30. Nama and address of parson who Stephen 5.	Radenti	2 111 P		reet	, Baltimo	re, Mary	land 2	1201	
State Registrar	31. Data filed (Month, Day, Year) NUV 1 4 LUUU	32. Registrar	S Signetura	alle						

DHMH 16 Rev 6/95



Please T

Type or Print In Black Indelible Inleading State of Maryland / Department of Certificate of	Health and Mental Hygiene 00 36104
Kenneth Wilson Sr.	2. Data of Death Month Day Vear November 13, 2000 12:50 p
street and number)	4b. City, Town, or Location of Death 4c. County of Death

Physician /Medical Examiner 1. Decedent's Name (First, Middle, Last,

4a Fecility Name (If not institution, giva

5. Social Security Number

Usual Residence of Decedent

179-20-5591

10e. Street and Number

10a. Stata

Director

Carroll

10b. County

Carroll

4224 Upper Beckleysville Road

Roland

6. Sex 1 ☑ M 2 ☐ F

Funeral

Director 28a-f show ed other than "natural", or lients 23s or 28s-f event, the Medical Exeminer must be notfills

Pages 1 and 2 should be Illad within 72 hours after death nent of Health and Mental Hygiere.

Int. If Item 27 is marked other than "natural", or Itema 23

Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰ Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondery (0-12) 17. Father's Name (First, Middle, Last) Joseph Franklin Wilson 19a. Informant's Name/Relationship (Type, Print) Clara Louella Wilson - wife 20a. Mathod of Disposition 20b. Placa of Disposition (Neme of cematery, cremetory or other place) Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from State Marburg Mem. Gardens 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee mosta 23e Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Due to (or as a consequence of) Physician/Medical Examine or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or as a consequence of) P.O. Box 68760, Dua to (or as a consequance of) after death.

Offector: After this certificate has been signed by the a d in by the funeral director, page 2 should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RO-CUTENIOUS Division of Vitai Records, Certification: To Be Completed by 25. Was case referred to medical examinar? 1 Yes 2 No 27. Manner of Death Natural 2 Accident 5 Pending Investigation 3 Suicide 6 Could not be determined Illeid in by 4 Homicide To the Hospital Medical 29e. Certifiar and manner stated. 29b. Signature and title of certifier

m. County General Hospital 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Dey, Year) | Yrs. | Months | Days | Hours | Min. | March | 9, 192 Westminster Carroll Birthplaca (Steta or Foraign Country) Parkton, 10d. Inside City Limits 10c. City, Town or Location 1 Yas 2 No Hampstead 10f. Zip Code 10g. Citizen of What Country? 21074 U.S.A. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian Black, White, etc. 1 ☐ Yes 2 ☐ (No Specify: Specify: White 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Supervisor Bridge Const. Railroad 18. Mother's Name (First, Middle, Maiden Sumame) Blanche Bell 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 4224 Upper Beckleysville Rd. Hampstead, Md. 21074 20c. Localion - City or Town, Slate Nov. 16, 2000 Hanover, Pa. 22. Name and Address of Facility Eckhardt Funeral Chapel 3296 Charmil Dr. Manchester. Approximate Interval Between Onsel and Death IC PULMONARY FIBROSIS

23b. Did tobacco use contribute to the cause of death?

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 1 ☐ Yes 2 No

3 Probably 4 Unknown

1 □ Yes 2 No

26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 1 Yes 2 No 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify)

(**Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceusa(s) end menner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. Licansa number

29d. Date şigned (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HTS.WESTMINST WASHINGTON

Registrar

31. Date filed (Month, Dey, Year) 14 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 0 36 105

				Ce	ertifica	ite of	Death		Re	g. No.		0100	
		1. Decedent's Neme (First, Middle, La.	st)	2011					. Dete of Death			3. Time of I	Death
	Physician	HELEN ELIZAT	BETH WILLIA	MS				1	Worth 1	1,200	OYear	8:10	am
	/Medical Examiner	4a Facility Neme (If not institution, giv					4b. City, Tow	m, or Loca	tion of Death	4c. County			
41	CXAIIIIIIEI	140 KINGSTON	DAAD				BALTI	MORI	F	BALT	IMOR	E	
	F	5. Social Security Number 6. S		lest birthday	() If Und	er 1 Yeer	If Under 2		Dete of Birth		-	laca (State or	Foreign
	Funeral Director	215-28-7938 Usuel Residence of Decedent	□M 20XF 6		Month	s Deys	Hours	Min.	(Month, Day, Aug. 16	, 1931	Coun	Z'AND	
200	1	10a. Stete 10b. County	10c. C	ity, Town or I	ocation					7	1	0d. Inside Cit	v Limits
e Mary	s or 28s-f shor be notified at Director	MD. BALTI	MORE	ESSEX								1 🗆 Yes	2 [XNo
6	be notified Director	10a, Street and Number			10f. Z	ip Code			10	g. Citizen of		itry?	
6	and burners of the second	5 BRETT COURT AP				21221				U.S.A			
O uther do	or hams 23s miner must Funeral	11. Meritet Stetus 1 Never Merried 2 Merried	12. Wes Decedent Ever in U Armed Forces? 1 Yes 2 X No If Yes, Give	J,S. 13	If Yes, sp	edent of I becify Cub	Hispanic Orlg en, Mexican, Specify:	in? (Specif Puerto Ric	ty Yes or No- can, etc.)	Ble	ce - Americ ck, White,		
005	D 6	3 ☑ Widowed 4 ☐ Divorced	Yeer or Detes:		111 165	2 140	Specify.			Specif	WH1	TE	
21215-0020 d within 72 hours at	ygiene. wer than "naturn rt, the Medical Completed	15. Decedent's Ed (Specify only highest gra		16e. Dec	edent's Us	uel Occup	petion during most	of working	1	6b. Kind of B	usiness/Ind	dustry	
121	up up	Elementery/Secondary (0-12)	College (1-4or 5+)				od)						
CI D	Co Hard	7		SALE	S CLI	ERK_				RETAI	-		
0 00	e ven	17. Father's Neme (First, Middle, Last)					18. Mother	's Neme (/	First, Middle, M	aiden Sumar	ne)		
Maryland	Merrico To	JOHN NOLAN					HELE	EN SAL	UTERS				
ar	Dia mile	19e. Informent's Neme/Reletionship (Type, Print)	19b. Mei	ling Addre	ss (Street	t end Number	or Rurel F	Route Number,	City or Town	State, Zip	Code)	
. 5	127 1 127	PATRICIA SADOWSKI	/DAUGHTER	7526	OLD	BATT	LE GRO	VE R	DAD, BAL	TIMORE	, MD.	21222	
Saltimore	H H H	20e. Method of Disposition		Plece of Disp cemetery, cri	position (Nemetory or	eme of other ple	ica)		Dete 2	0c. Location	- City or To	wn, State	
E de	nt: If	1 N Surial 2 □ Cremation 3 □ 4 □ Donetion 5 □ Other (Specific		EN HAV	FN CH	E'AFTE	RV 1	1/13	/2000	RAITTM	ORF	IARVIAN	ID
alti	epartmen reportant ny injury 008	21. Signature of Funerel Service Licer			22. Name	end Addre	ess of Facility				OKE, I	IAK/ LAN	V
0 1	DE SE	1	211.	-					FUNERAL				
		220 Posts Enter the disease or some	STARLE	1 Da not a	901 E	EASTE	RN AVE	NUE,	BALTIMO	RE, MAR	YLAND	21231 Approximate	
4		23a. Pert1. Enter the disease, or com shock, or heert teilure. List only	one cause on each line.	in. Do not e	nter the m	ode of dy	ng, such es c	ardiac or r	espiretory erre	St,	-	Interval Betw Onset and D	veen
	ysician		Anch of	1.	1		. /	1 ~				Oriset and D	99(1)
	Medical caminer	Immediate Cause (Final disease or condition	. Netast.	anc		w	3	wo	21		- 19		
		resulting in death)		or as a cons			V		POST I			0.10	-5.5
2	si si		b	10			100						103
BCUT	hysician and the burial-transit dical Examiner	Sequentially list conditions,	Due to (or as e conse	equenca o	f):							
68760,	physician and the burial-tra dical Exar	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	c								1		
87 ate	physicia as the bur edical	that initiated events resulting in death) Lest	Due to (or es e conse	equence of):							
W E	D												
BO)	for use		d								1		
. 8	the at hed for	Pert II. Other significant conditions of	ontributing to death but not re-	sulting in the	underlying	cause gi	ven in Pert f.		23b. Did tot	acco use co	entributa to	the cause o	f death?
P.O.	7 8 2								1 □ Ye	8 2 No	3 Prof	bably 4 t	Unknown
ds,	58 5								04- 11/		74b W	ere autopsy fi	ndings
Records,	page 2 should I								24e. Was an perform	ed?	av	aileble prior to	0
la v	as b										of	death?	
	page page								1 ☐ Ye	2 2 No	10	Yas 2	No
Vital	certificate has rector, page 2 Be Comp	25. Wes case referred to medicat examiner?					26. Plece	of Deeth (Check only one)		110	10
of Vita		1 Yes 25KNo	Hospitel: 1 Inpatient 2	ER/Outpatie	ent 3 l	DOA Ot	her: 4 Nur	sing Home	5 Resider	nce 8 XOII	ner (Specif	y) ghte	ne.
1 Of	erthis erai di n: To	27. Manner of Death	28a. Dete of Injury (Month, Day Year)	28b. Time		28c. Inju	iry et	28	d. Describe hor	w Injury occu	rred		
0 4	atio	Neturel 5 Pending investigation		Injury	М		Yes 2 N	lo					
Division	T the	3 ☐ Suicide 6 ☐ Could not be	289. Pieca of injury - At n	ome, farm, s	treet, fecto	ory, office		28			ber or Rura	i Route Numi	ber,
0 0	rs after death. al Director: After t led in by the funer; Certification:	4 Homicide	building, etc. (Speci	ry)					City or Town,	21616)			
ap de	neral y fille	29a. Certifier 12 Certifying Ph	ysician: To the best of my kno	owledge, dee	th occurre	d at the ti	ime, date end	plece, and	d due to the car	use(s) end m	anner as s	tated.	
To the Hospital	within 24 hours after death. To the Funeral Director: After consistently filled in by the funer Medical Certification.	(Check only 2 Medical Exam	niner: On the besis of examine and menner steted.	etion end/or I	nvestigetio	on, in my	opinion, deetl	n occurred	et the time, da	te end plece,	and due to	the ceuse(s)	1
_ t		29b. Signeture and settle of curtains	111 8.	RCEL	1 2	9c. Licen	se number		29	d. Dete signe	d (Month,	Dey, Year)	
	10	1/n/China	TAR	THOE O		00	TXCC	93	5	111	131	DO	
	YIX	20 Name and address of access	nomploted cause of death the	m 22a) /T	Dring	2	2003	1-			. 7	-	
- 1	UVI	30. Name and address of person who				0.4		D = 0 .) _ /	0100=	,
		Thomas Purcel 31. Dete filed (Month, Day, Year)	32. Registrass Sign	N. W	orke	SI	reet,	oalt	imore,	maryk	and	21287	
	State Registrar	MOVE	2000 1 here	البطسل	9	100	mekil						

					iviaryia		epartment of Certificate of		R	eg. No.	0 3	6106
Dhuninin	_	1. Decedent's Nam	e (First, Middle, La	st)					2. Date of Deat Month	h Day	Yeer	3. Time of Death
Physicia /Medica	_	Vernon	Bernar	d Y	oung,	Jr.			October			10:10 p.m
Examine	er	4a Facility Name (/	f not institution, giv	e street and nur	nber)			4b. City, Town, or L	ocation of Death	4c. County	of Death	
			gton Adve					Takoma P			gomery	
Funeral Director		5. Social Security N	1	ex ∏M 2□F	7. Age (In yn		months Day		8. Dete of Birth (Month, Day, Oct. 29	Year) , 2000	9. Birthpla Countr Mary	
1	1	Usual Residence of 10a, State	10b. County		10c. C	ity, Town	or Location				10	d. Inside City Limit
23a or 28a-f show ust be notified at	0	MD	Montgom	erv	S	ilve	Spring					t∰Yes 2□Ne
noti	Director	10e. Street and Nur	0	3			10f. Zip Code		1	0g. Citizen of \	Whet Countr	y?
4		603 S1:	igo Avenu	e. #505			20910	0		USA		
niner	by Funeral	11. Maritei Stetus	ed 2 Married	12. Was Dece Armed Fo 1 Yes If Yes, Giv Year or De	rces? 2∭ No e	U,S.	13. Was Decedent of if Yes, specify Cu		pecify Yes or No- Rican, etc.)	Blee	e - America ck, Whita, et	tc.
			15. Decedent's Ed	lucation	-1001	16a. I	Decedent's Usuel Occ	upation		16b. Kind of B	usiness/Indu	ustry
the Med	Completed	(Special Special Speci	ndary (0-12)	de completed) College (1 N/A	-4or 5+)		Give kind of work don life. DO NOT use retii N/A	e during most of work red)	king		N/A	
	Bec	17. Father's Neme	(First, Middle, Last)		4		11.52	18. Mother's Nam	e (First, Middle, I	Maiden Suman	10)	
a c	10	Vernon	Bernard	Young				Tonya	Marie V	Vashing	ton	
and a		19a. Informant's Na	me/Reletionship	Type, Print)			Melling Address (Stre				State, Zip (Code)
		Birth	a Drumhel Registrar	ier,			00 Carroll	Ave., Tak			20912	
		20a. Method of Disp	oosition Cremetion 3	Removal from	1	Place of cemetery	Disposition (Name of , crematory or other p	lace)	Dete	20c. Location -	City or Tow	m, Stete
	1		5 ☐ Other (Specif		Wa	sh.	Adventist		2000	Takoma	Parl	
#		21. Signature of Fu	neral Service Licer	1596	1		22. Name and Add	rees of Facility Was	hington	Advent	ist Ho	ospital
18		1/1/ak	an X	Laco	(20)		7600 Car	roll Ave.,	Takoma	Park,	MD 2	20912
		23a. Part1. Enter a	disease, or com	dications that o	aused the de-	ath. Do no	t enter the mode of d	ying, such as cardied	or respiratory are	est,	100	Approximate Interval Between
an cal ner		Immediate Cause (disease or condition resulting in death)	Final	le	mal		ty .					Settus
	ner	randing in dealing	9 4		Loue to	lor as a co	hisequence ot):	upture	20	Meuk	Eccu!	Fetus
bunal-trans	Exam	Sequentially list co if any, leading to in cause. Enter Unde	smediate drying		Due to	(or as a co	onsequence of):	1	V	1,500		
	Medical	Cause (Disease or that initiated events resulting in death)		С.	Due to	(or as a co	nsequence of):	187				
d for use as the	Physician/Med	Part II. Other signif	lcant conditions o	d.	ath but not re	multing in	the underlying cause :	olven in Part I	23b. Did to	bacco use co	ntribute to	the cause of death
10	by Phys								104	es 2 No	3 Probe	ably 4X) Unknow
2 should be	Completed							1100	24a. Was a perform	n autopsy med?	oom	re autopsy findings liable prior to apletion of cause eath?
for, page 2	00								1 D Y	00 2 NO	10	Yes 2□ No
	Be	25. Was case refer	red to medical					26. Place of Dea	th (Check only or	ne)		
	10	1 □ Yes 2 🖔	No	Hospital: 100	npatient 2	J ER/Out	nation1 3LI DOA		ome 5 Reside	ence 6 DOE	er (Specify)	
		27. Manner of Deat 1 ⊠Natural 2 ☐ Accident	5 Pending investigation	1	of Injury h, Day Year)	28b. Ti	ury W	ury at lork? □ Yes 2 □ No	28d. Describe h	ow injury occur	red	
d in by	ertific	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	288 Place	of Injury - At ig, etc. (Spec	home, fan	n, street, factory, offic		281. Location (St City or Town		ber or Rural	Route Number,
tely fill	edical	29e. Certifier (Check only one)	1X Certifying Ph 2 Medical Exer	niner: On the ba	best of my kr sis of examir er steted.	nowledge, netion and	death occurred at the for investigation, in my	time, dete and place opinion, death occu	, and due to the c rred at the time, d	ause(s) and m late and piece,	anner as sta and due to	ated. the ceuse(s)
To the comple		29b. Signature and	title of certifier	on	She	ul	29c. Lice 2 D 2	nse number	2	9d. Dete signe	12	Day, Year)
	-	20 Name and add	ess of person who									

DHMH 16 Rev 6/95

State

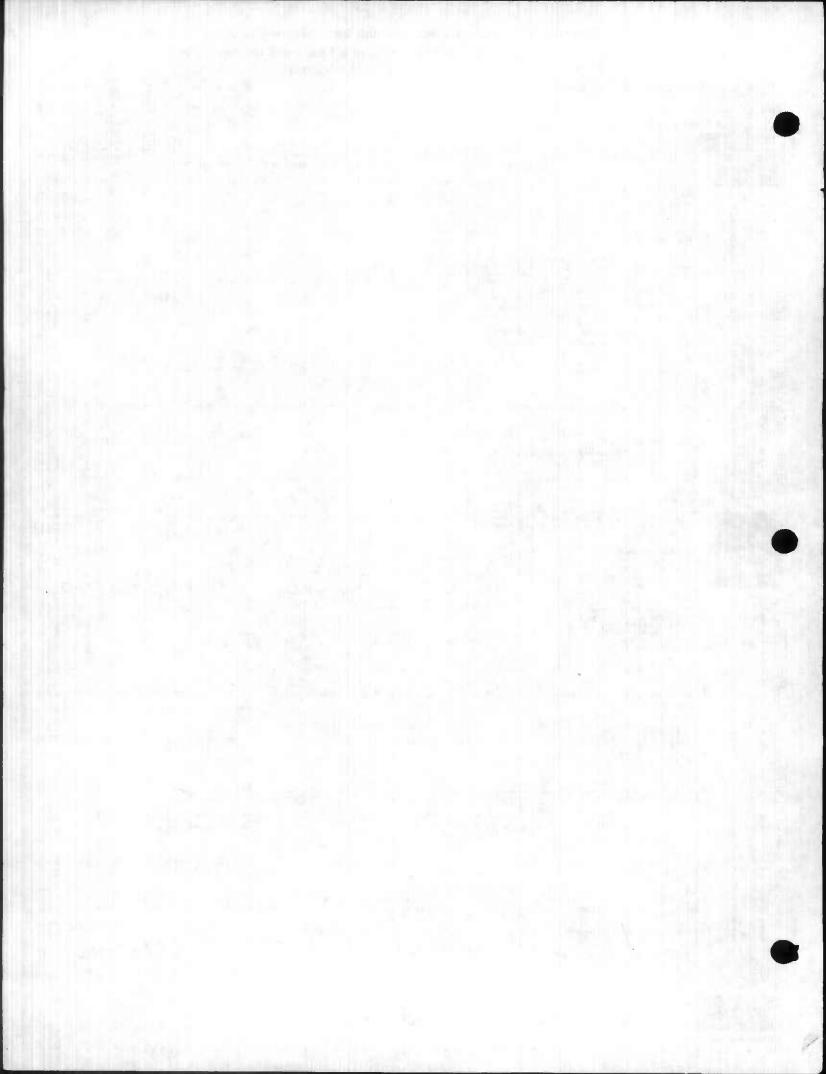
Registrar

31. Date filed (Month, Day, Year)

NOV 1 4 2000

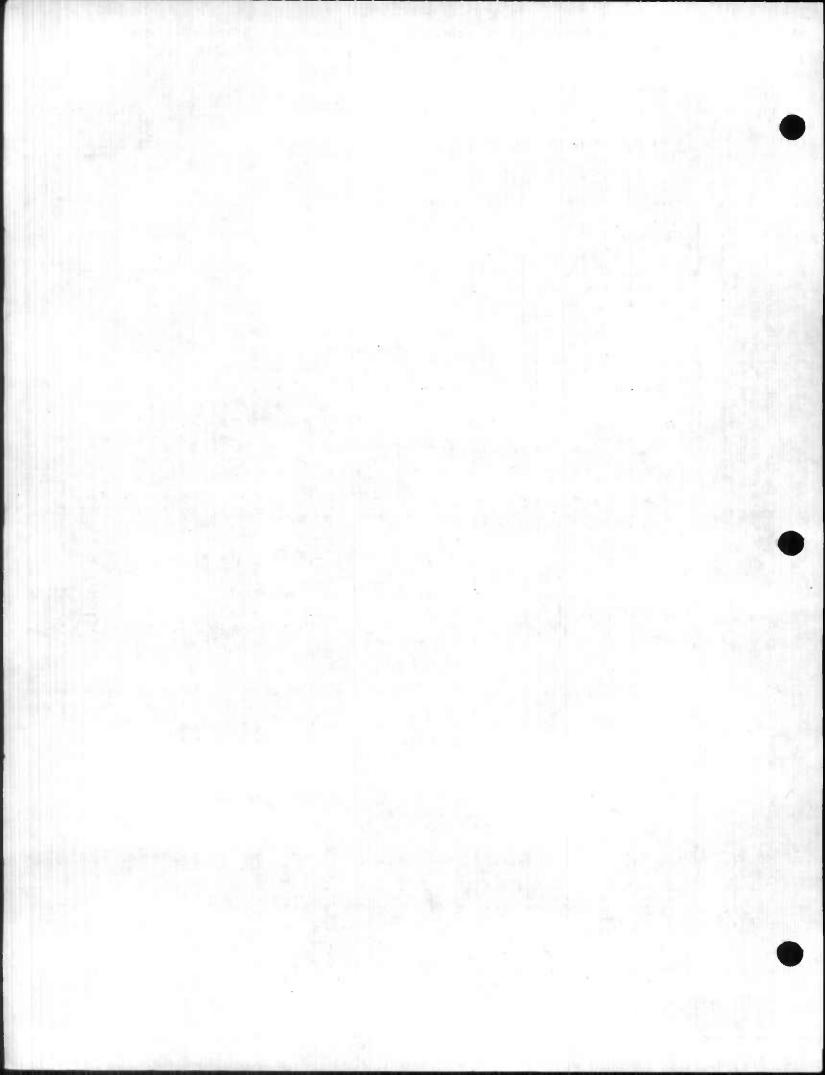
B. Sparks

32. Registrar's Signeture



State of Maryland / Department of Health and Mental Hygiene

ician	1 Decedes		41 4 44 4											
dical	ROS	t's Name <i>(First, I</i> E		MARY	LI	BERATT	0	YACU	RCIO		2. Date of D Month NOVEMB	Day	Year 000	3. Time of Death 7:05 PM
niner	4a Facility	Name (If not insti	itution, give	e street end nu	mber)			- 4	b. City, To	wn, or Lo	cation of Dea	th 4c. Coun	y of Death	
	CRO	FTON CON	VALES	SCENT C	ENTER				CROE				E ARU	NDEL
al	5. Social Se	curity Number	6. S		7. Age (In yrs.		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D	irth ley, Year)	9. Birth	place (Stete or Foreign ntry)
or		18-6407		□ M 2[X F		94 Yrs.					JUNE :	29,1906	OHIC) "
	10a, State	dence of Deceder			10c Ci	ity, Town or Lo	ocation							10d. Inside City Limits
5					100.0	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,								1 □ Yas 2XXIII
ector	MARY	LAND AN	NE A	RUNDEL			CROW 10f. Zip		LLE			10g. Citizen of	Million Cour	
ä		ST. STE	TATIONIC	c aurona	u DOAD		101. 210		032			U.S		rury :
era	11. Marilai		PHEN		edent Evar in U	18 12	Was Decer			ain? (Sa	poity Vas or N			can Indian,
Funeral		rer Married 2	Married	Armed Fo	rces?	7,5.	If Yas, spec	cify Cube	n, Mexicar	, Puarto	ecify Yas or N Rican, atc.)	Bi	ack, White,	
		lowed 4 Divo		If Yes, Giv	/a		1 ☐ Yes	2 XNo	Specify:			Spec	ify:	WHITE
l			edent's Ed			16a. Dece	dent's Usua	al Occupa	ation			16b. Kind of	Business/In	ndustry
	- Florida	(Specify only h	ighast gra	de complated)	45->	(Give	kind of wor	rk done d	durina mos	t of work	ing			
	Elements	ny/Secondery (0-	12)	Collega (1	1-40r 5+)	SE	AMSTR	ESS				CLO	THING	
	17. Father's	Neme (First, Min	ddie, Last)						18. Mothe	r's Name	e (First, Middle	e, Meiden Suma	me)	
	DOME	NICO			LIE	BERATTO			CARM	IELA		NAVA	RINI	
	19a. Inform	ent's Neme/Rela	tionship (Type, Print)		19b. Maill	ng Address	S (Street	and Numb	er or Run	al Route Num	ber, City or Tow	n, Stete, Zij	o Code 21032
	ANGE	LINA C.	JONES	S (DAU	GHTER)									LLE, MD.
	The state of the s	d of Disposition				Place of Dispo	osition (Nen	ne of	a)	1	Date 1/11/	20c. Location	- City or T	own, State
		rial 2 ☐ Crema nation 5 ☐ Oth			Steta	CEDAR					2000	BROOK	T.VN D	ARK, MD.
		re of Funeral Ser	_	12	/		2. Name en							ME, P.A.,
		//	/	///		1	SECO	ND A	VENUE					D. 21061
_	23a Parti	Enta The (Sana	a Ar agray	plications that o						•				
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State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 3. Time of Death 1. Decedant's Nema (First, Middle, Last) 2. Data of Death Month Dev **Physician** NOVEMBER 1, 7:50 AM 2000 VIVIAN KANTER ARNOLD /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, giva street end number) 4c. County of Death Examiner BETHESDA MONTGOMERY MANOR CARE HEALTH SERVICES Birthplace (State or Foreign Country)
 MARYLAND If Under 1 Yaar | If Under 24 Hrs 5. Social Security Number 8. Dete of Birth (Month, Day, Year) 7. Aga (In yrs. lest birthdey) **Funeral** Deys 1 M 2 X F Months Hours Yrs. 07-21-1910 90 Director 216-44-6819 Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. tnside City Limits MD MONTGOMERY ROCKVILLE 1 Yas 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1801 EAST JEFFERSON STREET 20852 USA Funeral 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yes ≥ 2 Ø No If Yes, Give Yaar or Datas: Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indian. Black, Whita, etc. 1 Never Merried 2 Merried WHITE 1□ Yes 2Ĭ No Specify by 3 ☐ Widowed 4 ☒ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done duning most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) Elemantery/Secondery (0-12) College (1-4or 5+) ADMINISTRATIVE-SECRETERIAL U.S. GOVERNMENT 12 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fathar's Nama (First, Middle, Last) Be BESSIE SHAPIRO PHILIP KANTER 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 9825 CCNESTOGA WAY, POTOMAC, 20854 MARYLAND HOWARD M. ARNOLD/SON 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stets NOV. 1, 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State KING DAVID MEMORIAL GDNS 4 ☐ Donation 5 ☐ Other (Specify) FALLS CHURCH, VA 2000 21. Signeture of Funerel Service 22. Name and Addrass of Fecility EDWARD SAGEL FUNERAL DIRECTION, INC. 23a. Pent1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory errest,

Approximate Approximata tnterval Between Onset and Deeth Immediate Ceusa (Final disease or condition resulting in daeth) Ormun Dua to (or es e consequance of): Physician/Medical Examin My letterson Due to (or sa consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last Dua to (or as a consequence ot): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 Yas 2 No 3 Probably 4 Nnknown g 24b. Wera autopsy findings evailable prior to 24a. Was an autopsy performed? Completed completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yas 2 12 No Be 25. Was case raferred to medical 26. Place gl-Deeth (Check only one) Hospital: Other: 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28e. Dete of Injury (Month, Dey Year) 28b. Time of 27. Menner of Deeth 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation 1. Neturel 1 Yas 2 No 2 Accident 28t. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, atc. (Specify) 4 Homicida 1 Certifying Physician; to the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as steted.
2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29a. Certifier edical (Check only one) 29b. Signature and title of certified 29c. Licensa number 29d. Dete signed (Month, Day, Year) 0 30. Nama and addrass of pa

State Registrar

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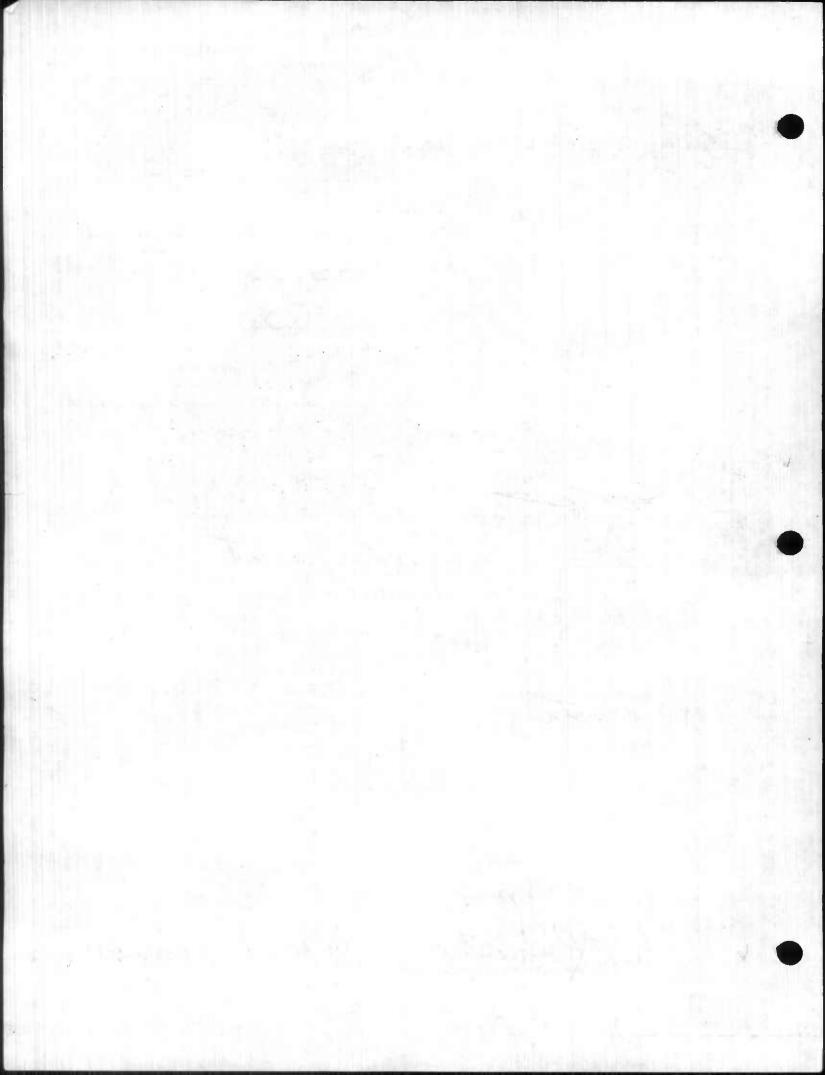
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ELLIOT R. GOLDSTEIN, MD, FCCP, FACP, 9410 OLD GEORGETOWN RD, BETHESDA, MD



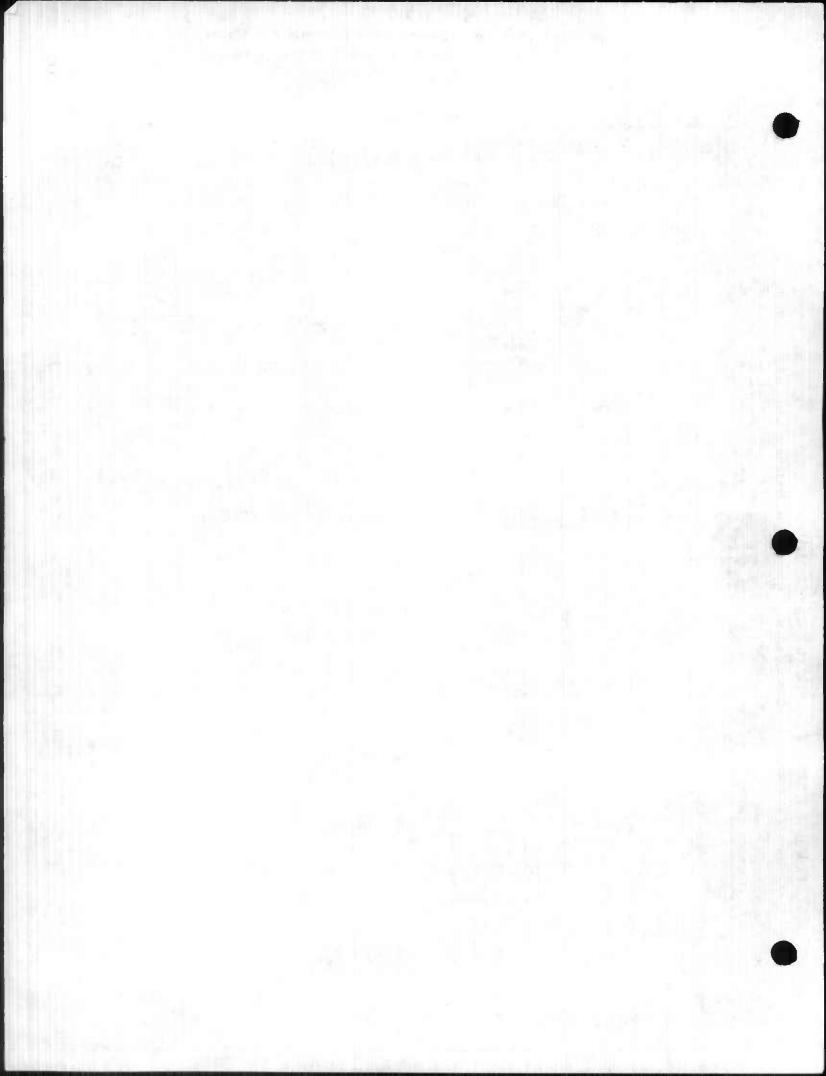
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** Joseph Arena October 29, 2000 8:42PM /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death **Examiner** 7. Age (In yrs. last birthday) | If Undar 1 Year | If Undar 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Portion of the Co. 22, 19. Suburban Hospital Montgomery 5. Social Security Number Birthplace (Stata or Foraign Country) **Funeral** 1⊠M 2□F 020-18-5223 **Director** 1917 Massachusetts Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yas 2 No Maryland | Montgomery Gaithersburg 10e, Street and Number 10f. Zip Coda 10g. Citizen of What Country? 8 228 21 Framingham Court 20879 United States 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☑ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married ã Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Year or Dales: WWII 15. Decedent's Education (Specify only highest grads completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Manager Construction 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental Pages 1 and 2 should be Pasquale Arena Emanuela Mastroli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) nt of Health a If Item 27 is 21 Framingham Court, Millicent E. Arena/Wife Gaithersburg, Maryland 20879 Baltimore, 20b. Place of Disposition (Name of cametery, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State Dele November 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stata Silver Spring, 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 3, 2000 Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 MO1126 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Acute myocardial infunction tmmediate Cause (Final disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): Physician/Medical Due to (or as a consaguance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown Py 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24e. Wes an autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpalient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifiar 29c. Licanse number 29d. Data signed (Month, Day, Year) V. Robert Buselles 04115 20+ 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) H. Robert Birschbach, M.D. 6320 Democracy Blvd., Bethesda, Maryland 20817-1664 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 03 Registrar

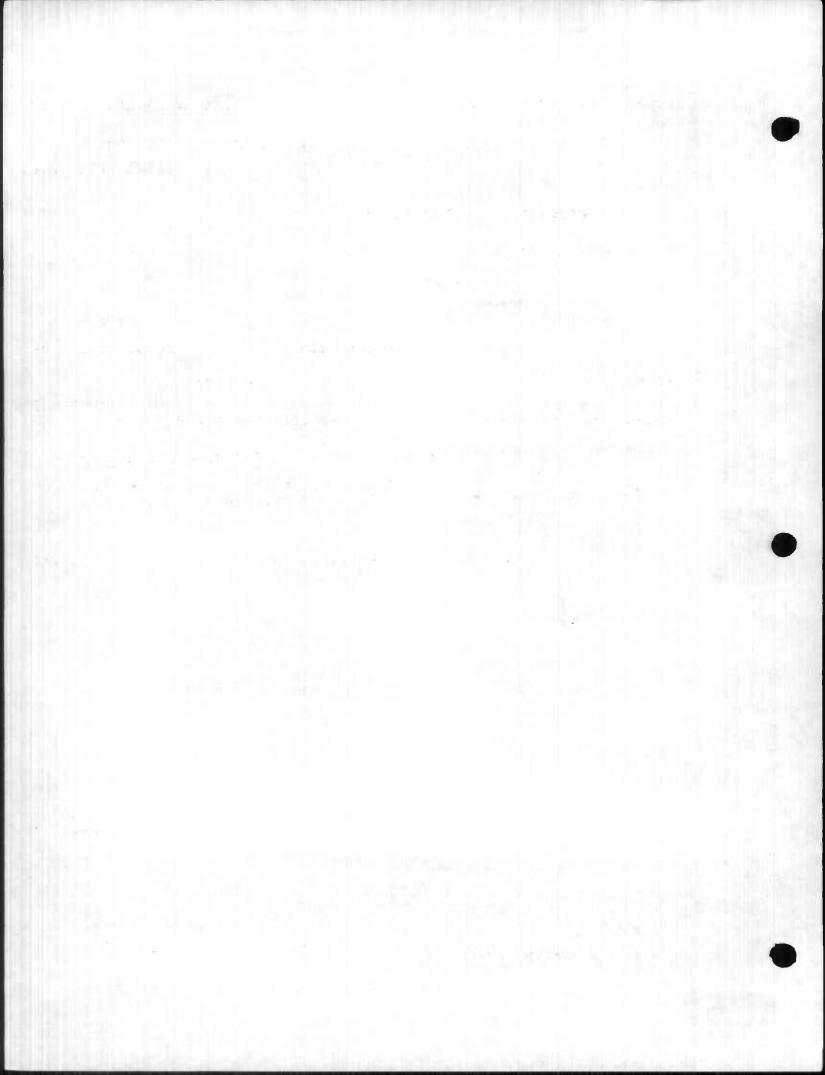
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State of Maryland / Department of Health and Mental Hygiene $\Omega \Omega = 2C + 1 + \Omega$

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/Medical Examiner	4a Facility Name (If not insti							4b. City, Town, or				11.220
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filed within 72 hours effer deeth with the Maryland Hygiene. Ther than "natural", or items 23s or 28s-f show ont, the Maryland Everyment must be northed a s Completed by Funeral Director	11. Marital Status 1 Never Married 2		12. Was Deceda Armed Force 1 XYas 2 If Yes, Give Yaar or Data	s? 19.	13			dispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		e-American ck, Whifa, ato y: Whit	0.
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0 8 2	that initiated evants resulting in death) Last	J	d	Due to (or as a consec	quenca of)						
e atter	Part II. Other significant cor	ditions co	ntributing to death	but not re	sulting In the u	ındəriying	cause giv	van in Part i.	23b. Did	tobacco use co	ntributa to ti	he cause of death?
igned by the attendir be detached for use by Physician/A									狘	Yes 2□No	3 Proba	bly 4 Unknown
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yecten: Ine law is certificate hes b director, page 2 s To Be Compli									10	Yes 2⊠No	101	Yes 2 No
certificate rector, pag	25. Was case referred to me axaminar?	-	Hospital:				Oth	ADP'	ath (Check only			
	1 ☐ Yes 2 ☑ No 27. Manner of Death		1 ☐ Inpe		28b. Time o		UA	4 U Nursing I	fome 5 ☐ Res	denca 6XOth		sisters
uithin 24 hours efter death, within 24 hours efter death, To the Funeral Director: After this certific completely filled in by the funeral director. Medical Certification: To Be (1 Natural 5 Pe	nding astigation ald not be	(Month, I	Dey Year)	Injury	М	1 🗆	rk? Yes 2□No		Street and Numl	16	sidence
us effection by led in by	4 ☐ Homicide de	tarmined	building,	etc. (Speci	nome, farm, st	raat, racto	y, onice		City or To	wn, Stete)	or or ridia. r	Toute (varioe),
Completely filled in by Medical Certification	29a. Cartifiar 1⊠ Cert (Check only 2 Med one)	Ifying Phy Ical Exam	elcian: To the be- iner: On the basis and manner	of examina	owledge, deat ation and/or In	h occurrac vastigation	at the tin	me, date and place opinion, death occi	a, and dua to the urred at the time	causa(s) and madate and placa,	annar as stat and due to th	ed. na causa(s)
Toth	296. Signatury ago surg of o	rather				29	c. Licens	se number		29d. Date signe	d (Month, Da	ay, Year)
8	30. Name and addrass of per	son who	ompleted cause of	f death (Ite	m 23a) (Type,	Print)	D08	754		Nov.1	, 200	0
	Thomas A.						ay	Ctr.Dr.	Greenb	elt.Md	207	7.0
State	31. Date filed (Month, Dey,)	ear)	32. Regi	strar's Sign	ature	-	,	,				



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death Month **Physician** Thomas E. Alexander October 12:07 AM 24, 2000 /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 24 Hrs. 8. Deta of Birth (Month, Day, Year) If Under 1 Yeer 5. Social Security Number 7. Aga (in yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Days 1⊠M 2□ F 052-26-6394 68 Yrs Director August 17, 1932 New York Usual Rasidence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland | Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 19104 Plummer Drive 20876 United States Funeral 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or Notif Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11 Marital Status 72 hours after 1 ⊠ Yes 2 □ No
If Yas, Giva
Year or Detes: 1951-1955 1 ☐ Never Merried 257 Merried Saltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: à White 3 Widowed 4 Divorced 'natural' Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry filed within 18 Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer IBM 18. Mothar's Nama (First, Middla, Maiden Sumama) 17. Father's Nama (First, Middle, Last) Mental Pages 1 and 2 should be and Mental Thomas Alexander Susan Katherine Petro 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Streat and Number or Rural Routa Number, City or Town, State, Zip Code) 19104 Plummer Drive, Germantown, Maryland 20876 Department of Health important: If item 27 Dorothy L. Alexander/Wife 20b. Placa of Disposition (Nama of cemetary, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Steta October b 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval Irom Stata Johnson City, New York Calvary Cemetery 30, 2000 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Addrass of Facility Robert A. Pumphrey Funeral Home/ 21. Signatura of Funaral Sarvice Licenses Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 MO1126 23a. Part1. Entar tha disaase, or complications that caused tha death. Do not antar the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximeta ntarvai Batween Onsat and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Acute Myocardial Infarction Minutes **Examiner** Due to (or es e consequança of): Examiner Coronary Artery Disease Years The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediata causa. Entar Undarlying Cause (Disaase or injury that initiated evants rasulting in death) Last use as the bunal-tran Dua to (or as a consequanca of): Box 68760. signed by the attending physician I be detached for use as the burn Physician/Medicai Due to (or as a consequence of): Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yee 2 | No 3 | Probably 4 | Unknown þ 24b. Ware autopsy findings available prior to completion of causa of death? page 2 should Be Completed 24a. Wes an autopsy performed? this certificate has 1 Yas 21 No 1 ☐ Yas 2 ☐ No or Attending Physician: after death. director, 25. Was casa rafarred to medical 26. Placa of Deeth (Check only ona) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Medical Certification: To 1 Yas 2 No Director: After thic 28a. Data of Injury (Month, Day Year) 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Panding investigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicida 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Plece of Injury - At home, ferm, street, factory, office building, atc. (Specify) filled in by 4 Homicida To the Hospital
within 24 hours a
To the Funeral C 29a Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and dua to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigetion, in my opinion, death occurred et the time, dete and place, end dua to the cause(s) and manner stated. 29b. Signature and little of certifier 29d. Data signad (Month, Day, Year) 29c. Licanse number 15+1 October 24, 2000 30. Name and addrass of person who completed causa of death (ttem 23a) (Type, Print) Frank Listelb, M.D. 9901 Medical Center Drive, Rockville, Maryland 20850

DHMH 16 Rev 6/95

State

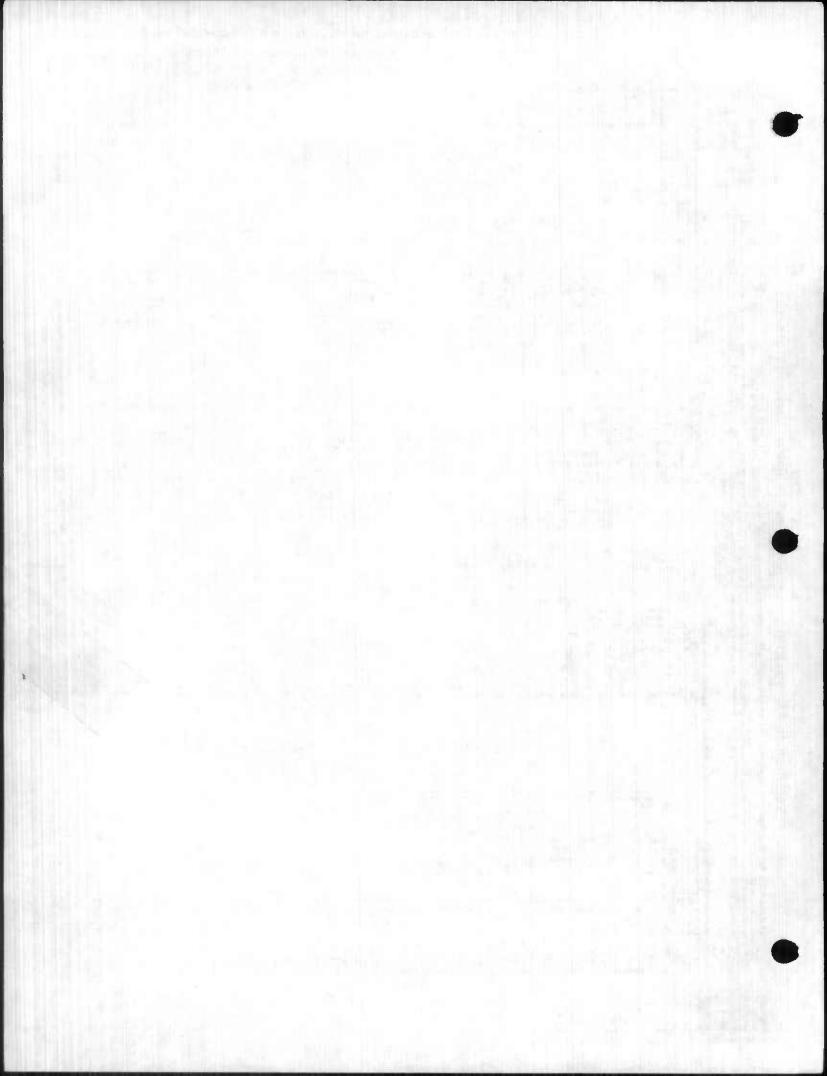
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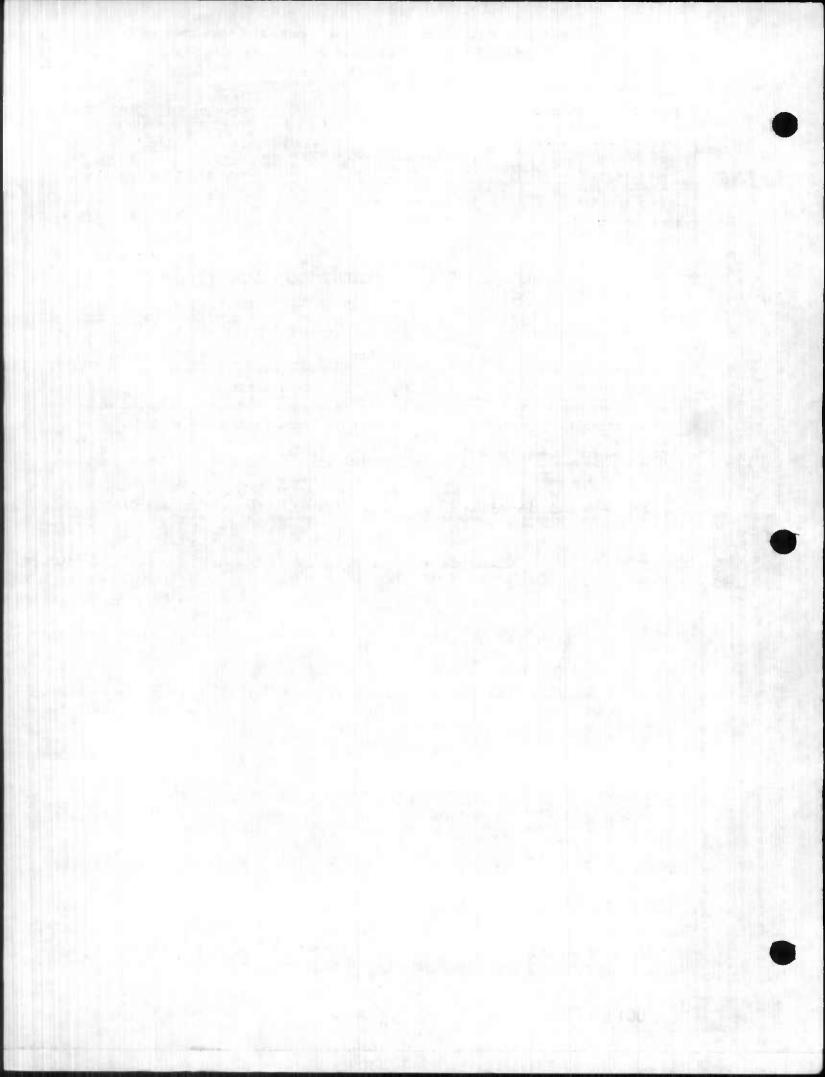
32. Registrar's Signatura



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State of Maryland / Department of Health and Mental Hygiene 00 36112

				Certifica	ate of	Death		Reg. No.))	0112
Physician	1. Decedent's Name (First, Middle,	.ast)					2. Date of De	eath Day	Year	3. Time of Death
/Medical	Rachel Mary And	erson					Octobe	er 20 :	2000	2145 P
Examiner	4a Facility Name (If not institution, g	ive street and number)			4b. City, Town, o	or Location of Deet	h 4c. County	of Death	
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	Usual Residence of Decedent 10a, State 10b. County		10c City To	wn or Location	1100				10	d. Inside City Limits
ner must be notified at one must be notified at uneral Director	Maryland Cecil		Elkto							1 ☐ Yes 2 ☑ No
be notified Director	10e. Street and Number				Zip Code		-	10g. Citizen of V	Vhat Count	rv?
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by Funeral	11. Marital Status 1 Never Merried 2 Merried	If Yes, Give	?			Hispanic Origin? ean, Mexican, Pu Specify:	(Specify Yas or No erto Rican, etc.)	14. Race Blec	e - America k, White, e	tc.
	3 ¼ Widowed 4 □ Divorced	Year or Dates:	100	- Described II	la val Osav			10h Kind at Bu	Whi	
Completed	15. Decedent's (Specify only highest (Secondary (0-12)		5+)	a. Decedent's U (Give kind of life. DO NO: Homemak	work done Tuse retire	during most of w	vorking	16b. Kind of Bu		
	17. Father's Name (First, Middle, La	st)		Homemak	CI	18 Mother's N	leme (First, Middle			
o Be	Richard Spratt						Keithle		-/	
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	Lydia Quesenber						Rising St			
	20e. Method of Disposition	Ty/Daughte		of Disposition (i		Lane,	Date	20c. Location -		
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	23a. Pert1. Enter the disease, or co shock, or heert tailure. List on	mplications that cause	d the deeth. Do	not enter the n	node of dy	ing, such as card	liac or respiretory	rrest,		Approximate Intervel Between
ian cal ner	Immediate Cause (Final disease or condition resulting in deeth)		olecu							7-4 week
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Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events		Due to (or es a	a consequence	ot):					
edicai	Cause (Disease or injury thet Initiated events resulting in death) Last	С	Due to (or es e	consequence of	of):					
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/ Physician/	Part II. Other significant conditions	contributing to death t	out not resulting	in the underlyin	o cause o	ven in Pert I.	23b. Dld	tobacco use cor	ntribute to	the cause of death?
y Physician/N							1 🗆	Yee 2 10 No	3 Prob	ebly 4 Unknow
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director, page 2 s To Be Compli	25. Was case reterred to medicat					26. Plece of D	Deeth (Check only	one)		Davel
_	axaminer? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpati	ent 2 ER/C	Outpatient 3	DOA O	her: 4 Nursing	g Home 5 ☐ Res	idence 6 250th	er (Specify	Daughter' Residence
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completely filled in by the funeral Medical Certification:	29e. Certifier 1 Certifying I (Check only one) 2 Medical Ex	Physician: To the best aminer: On the basis of end menner s	of examination e	ge, deeth occurr and/or investiget	ed et the t ion, in my	ime, dete and pla opinion, death o	ice, end due to the courred at the time	ceuse(s) end ma date and place,	nner as sta and due to	nted. the cause(s)
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y	30. Name and address of pelsen wh									
	Joseph Weidner,			1 1			Sun, Mary	land 219	11	
State	31. Dete tilled (Month, Day, Year)		rer's Signature	1 1	nekri			100		



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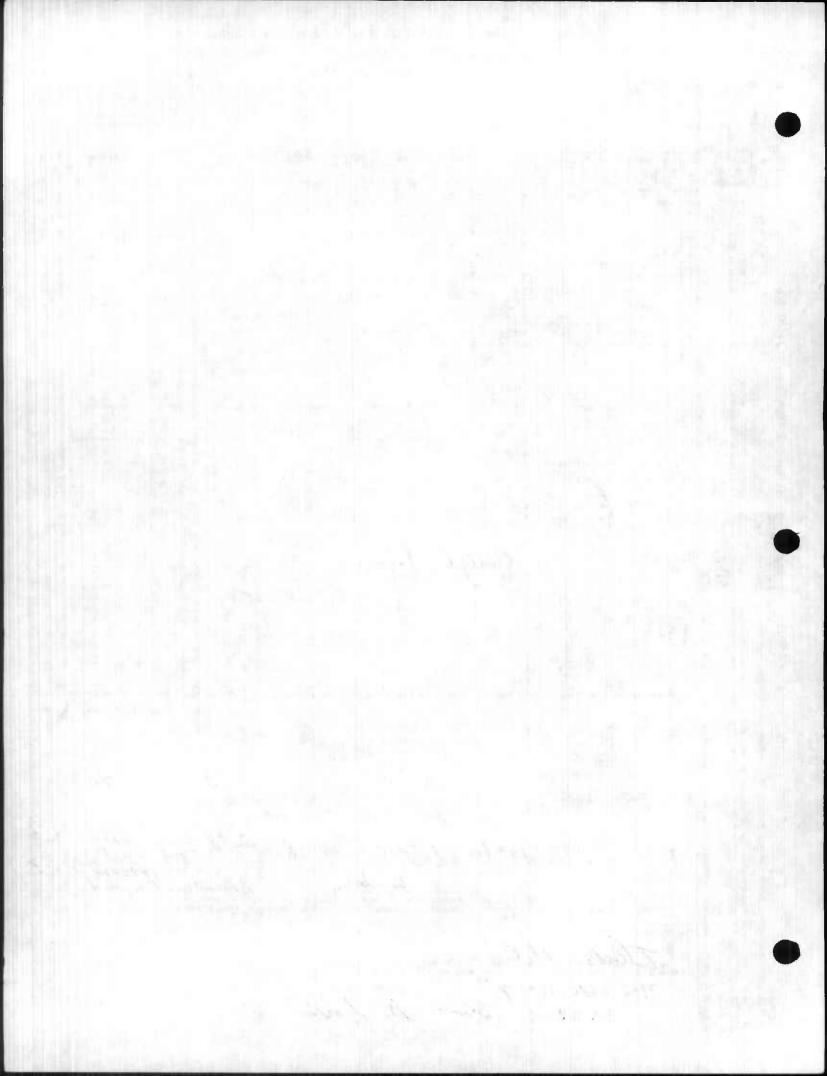
State of Maryland / Department of Health and Mental Hygiene

VV							Ce	rtificat	e or	Death		F	eg. No.			
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	_/Medical		y Name (If not institu				, 11.			4b. City. To	wn, or Lo	ocation of Death	4c. Count			
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	hour hour hour hour hour hour hour hour	29a. Cert		ying Phys	ician: To the	best of my kr	nowledge, dea	th occurred	at the t	ime, date ar	nd placa,	and due to the	ause(s) end m	anner as	stated.	- (-)
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			/ chedo	m l	teki	187	40									
		30. Neme	and address of pers	on who co	npleted cau	se of death (Ite	em 23a) (Type	. Print)								

State Registrar

31. Date filed (Month, Day, Year) 1. NOV 0 2 2000

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended item#1,(per MD), 11-03-00,SRR, Talbot 1. Decedant's Nama (First, Middla, Last) 2. Deta of Death 3. Time of Death Genevieve Month **Physician** Behme Roeper October 26, 2000 7:43 p.m /Medical 4b. City. Town, or Location of Deeth 4a Facility Nama (If not institution, giva street and number) 4c. County of Deeth Examiner Jackson Ave St. Michaels 1109 Talbot If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 13, 1 5. Sociei Sacurity Number 6. Sax 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2KF Days Hours Yrs. 219-42-4547 83 1917 Illinois Director Usual Rasidence of Decedent 10a State 10b. Count 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examples must be notified at the Maryler 1 Yas 2 XNo Director Maryland Talbot St. Michaels 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1109 Jackson Ave. 21663 U.S.A. Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ∑ No If Yes, Give Yaar or Datas: 14. Race - American Indian, Black, White, atc. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) Peges 1 and 2 should be filed within 72 hours after nent of Heelth end Mental Hygiene.
nt: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) 12 4 Housewife Home traumatic event, 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) Be George E. Roeper Eva Kramer 19a. Intormant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Nicholas F. Behme Husband 1109 Jackson Ave. St. Michaels, Maryland 21663 other 1 Saltimore. 20b. Place of Disposition (Name of cemetery, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Data 1 Burial 2 X remation 3 Removal from State injury or permit. Pege Department important: If any injury or 4 ☐ Donation 5 ☐ Othar (Specify) Capitol Crematory Nov. 3, 2000 Dover, Delaware 21. Signature of Femeral Service Licenses 22. Name and Address of Facility Harrison E. Leonard Funeral Home 312 S. Talbot St. St. Michaels, Maryland 21663 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 00 Approximate Interval Between Onsat and Death **Physician** /Medical Immediata Ceuse (Final disease or condition rasulting in death) Pseudolullar **Examiner** Before Dua to (or as e consequence of): Examiner Cultiple revelor physician and the buriel-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Causa (Disaasa or injury that initiated events resulting in daath) Last Due to (or as a consequence of): 2000 atrial film Physician/Medical Due to (or as a consequance of) 98 signed by the ettending I be detached for use es Pert II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown none p 24b. Were autopsy findings available prior to completion of ceuse of deeth? Completed 24a. Was an autopsy performed? hes 1 Yes 2 No 1 ☐ Yas 2 ☐ No Division of Vital director, 25. Was case referred to medical exeminar? Be 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Mannar of Death 28d. Describe how injury occurred 28b. Tima of 28a. Data of tnjury (Month, Day Year) 28c. injury at Work? Certification: 1 Natural 5 Pending death. 1 Yes 2 No invastigation offer death Director: A 2 Accident 6 Could not be datamined 3 Sulcide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, tarm, straat, tactory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29e, Certifier 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certitier 29c. License number

State Registrar Robert W. Trever M.D. 7696 Ocean Gateway Easton, Maryland 21601
31. Data tiled (Month, Day, Year)
NOV 0 1 2000

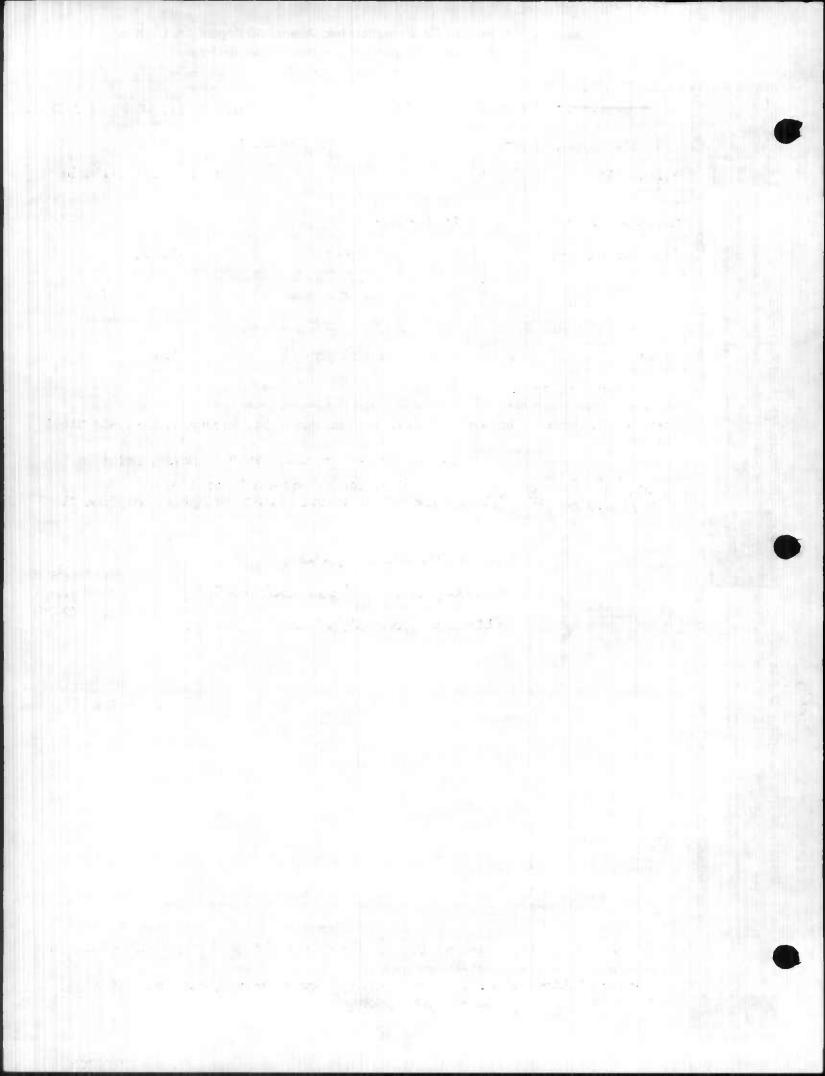
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Robert W. Trever, M.D.

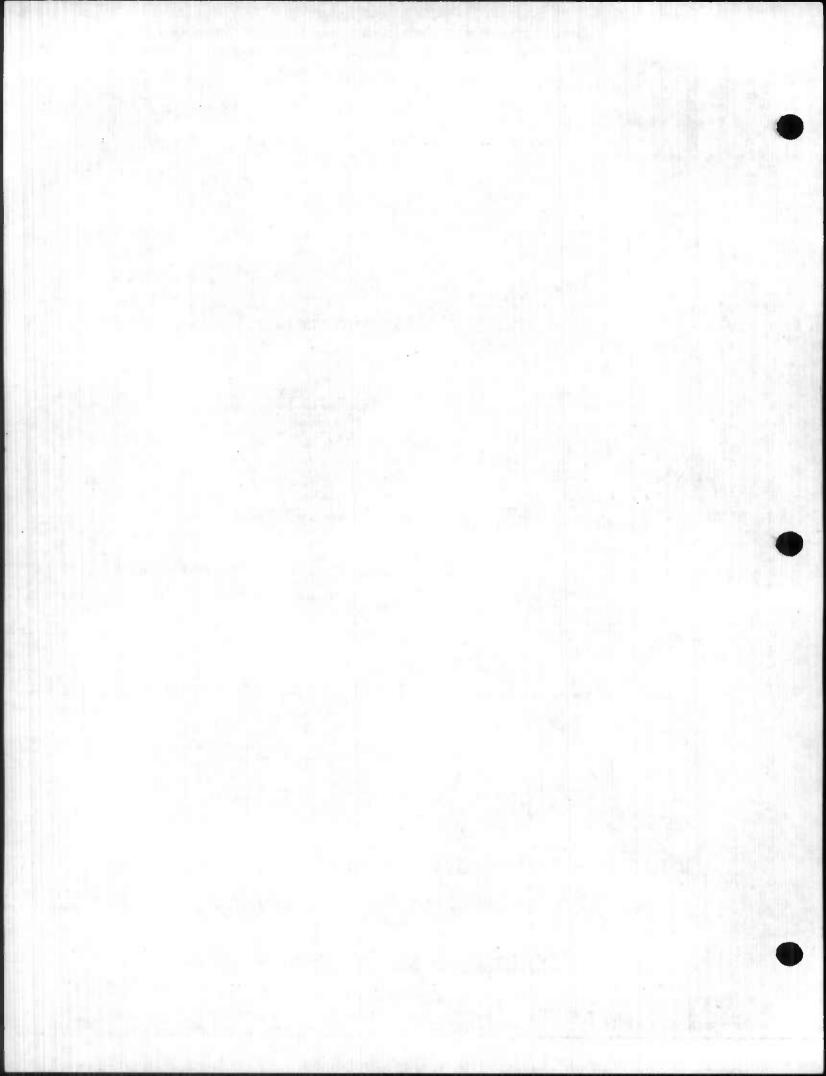
30. Nama and eddrass of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 35115

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	21. 9	Signeture of Funeral Service	Licensee	M	00198	Rober 8	and Addre	Sof Fecility Pumphre lontgome	y Funera ry Avenu nd 2085	1 Home/F	Rockvill	e, Inc.
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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. U Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month October Douglas 30, 2000 Briggs 10:15 am 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Genesis Eldercare- Layhill Center Silver Spring Montgomery 8. Dete of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 6. Sex 1 2 M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 81 438-01-8975 Louisiana **Usual Residence of Decedent** 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Washington 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1821 Sudbury Lane 20012 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner Dry Cleaners 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anderson Briggs Mamie Wildridge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stele, Zip Code) Fernal J. Briggs / Son 1821 Sudbury Lane, NW, Washington, DC 20012 20b. Place of Disposition (Name of carnetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Derial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 11/2/00 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligans 22. Name and Address of Fecility Francis J. Collins Funeral Home, Inc. milh 500 University Blvd., W, Sil Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. 500 University Blvd., W, Silver Spring, MD 20901 Approximate Interval Between Onset and Deeth Immediate Cause (Final SEPSIS disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (o as a consequence of): Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tobacco use contribute to the cause of death? 1 ☐ Yea 2 ☐ No 3 ☐ Probably 4 € Unknown De meutia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 Q No 1 ☐ Yes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Director DC

Funeral

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Hygiene.

t. Pages 1 and 2 should be fill tment of Health and Mental H rtart: If Hern 27 is marked off njury or other traumatic ever

permit. Page Department of Important: If any injury or once.

the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0020

Examiner the buriel-transit Physician/Medical 997 by Completed page 2 funeral director, Be Certification: To

Attending Physician: The law requires that the death certificate be asscuted

certificate

this

s after death.

To the Hosp within 24 ho To the Fune completely fi

6 Hospital 24 hours a

Box 68760.

Division of Vital Records, P.O.

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28c. tnjury at Work? 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

edical

Natural
Accident

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier my

D38262

October 30, 2000

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. Mendlirata

Soute 349 2401 Research BLVD Rockville

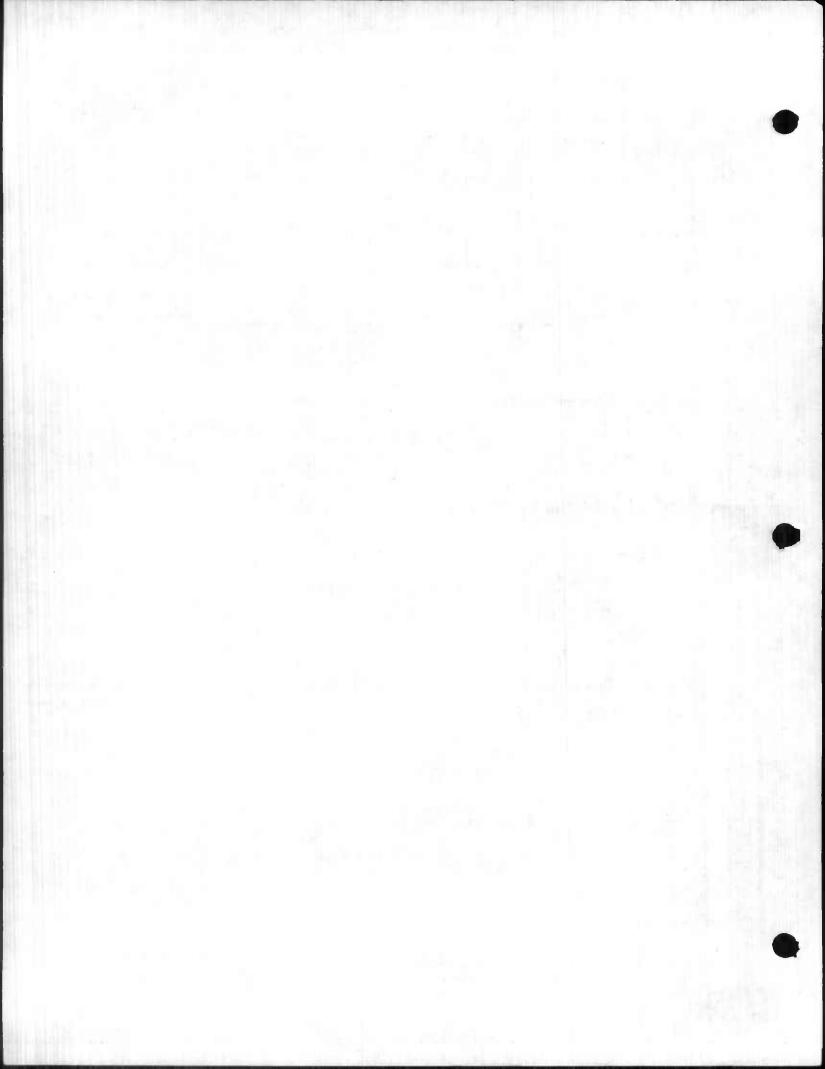
State Registrar 31. Date filed (Month, Day, Year) OCT 31 2000

5 Pending

6 ☐ Could not be



oouls



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. AMEND ITEM: 10E PER F.H. G789 11-16 State of Maryland / Department of Health and Mental Hygiene AMEND FIEM: 7 PER F.H. G789 11-14-00 WR. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month OCT. Day **Physician** 20 LICHAR 2:00 pm 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 10 W. Chestnut Street Washington Funkstown If Under 1 Year | Months Days 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Hours 80-81 1 M 2 F 20-05-3076 Director Usuel Residence of Deceden the Maryland 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow the Medical Examiner must be notified at MANYLAUL Washington 1 ☐ Yes 2 No Funeral Director 10e. Street end Number 10 W GHESINUT SIREFIT 10f. Zip Code 10g. Citizen of What Country? 6 death with 7 Нете 23а 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Meritel Stetus 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 'natural', or 1 ☐ Yes 2 No Specify: Specify: white ò 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filled within nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than 1rry or other traumatic event, the Marky or other traumatic event, the Marky Elementary/Secondery (0-12) College (1-4or 5+) expeditor aircraft 17. Father's Neme (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) Be Rosa L. Wolfe Robert L. Bailey 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5805 Wyngate Drive Bethesda, MD 20817 19e. Informent's Neme/Reletionship (Type, Print) Doris B. Grimm/sister 5805 Wyngate Drive Bethesda, MD 20e. Method of Disposition 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20c. Location - City or Town, State 1 Burier 2 Cremetion 3 Removal from Stele permit. Page Department of Important: If 4 Donation - 6 Other (Specify) 21. Signature of Funera Service Licenses de State Anatomy Board Director 655 W. Baltimore Street 21201 Baltimore, MD 1660 . Enter the disease, of complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, k, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final diseese or condition resulting in deeth) Examiner Examiner bunial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): physician a Box 68760. Physician/Medical Due to (or as a consequence of): Pert II. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown been signed l should be det Records, à 24b. Were autopsy tindings available prior to completion of ceuse of death? Completed 24a. Wes an autopsy performed? The law 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Division of Vital Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Dete ol Injury (Month, Day Year) 27. Menner of Beath 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? or Attending 1 (ANatural 5 Pending investigation death. 1 Yes 2 No 2 Accident after death 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide • Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier completely within 2 To the

State Registrar

31. Date liled (Month, Day, Year) 2000 NOV

29b. Signature and title of certifier

30. Name and address of person who co

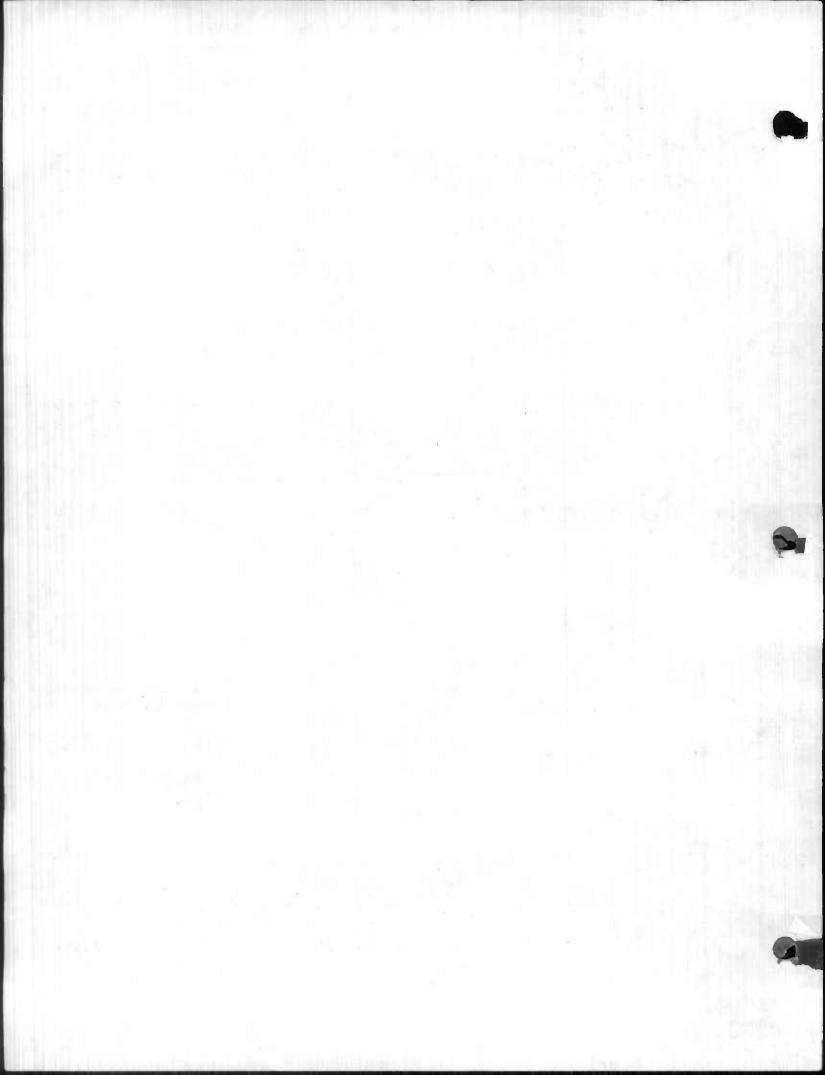
Registrar's Signeture

29c. License number

29d. Date signed (Month, Day, Year)

To the

23g) (Type, Print)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death 3. Time of Death Month HELEN H. BLUNT 1405 octobal 2000 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death SUBURBIN LOSPITH BUSTINESOA MONTBOAGLY If Under 1 Year | If Under 24 Hrs. 5 Social Security Number 8. Date of Birth (Month, Day, Year) Oct. 14, 1925 6 Sex 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) Months Days Hours 1 M 2 X F 75 Texas 449-32-0073 Yrs. Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5411 Moorland Lane 20814 United States 14. Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 21X Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Technical Writer Chemistry Magazine 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Thomas J. Holmsley Leah Allen 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert F. Blunt/Husband 5411 Moorland Lane, Bethesda, Maryland 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State October Montgomery Crematorium, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 27, 2000 Bethesda, Maryland 21. Signeture of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy 7557 Wisconsin Avenue Chase, Inc. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Chase, Inc. Onset and Death Immediate Cause (Finat disease or condition resulting in death) CONGESTIVE HEART FAILURE Due to (or as e consequence of) MULTISYSTEM PAILURE Due to (or as a consequence of): THROMBON SUPERLIDE MESENTERIC UEIN Due to (or es e consequenca of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contributs to the cause of death? 9/2/00 1 Yas 2 No 3 Probably 4 Unknown

Physician /Medical Examiner Examiner

Physician/Medical

à

Be Completed

Certification: To

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page 2 should

the Director:

filled in by

Physician

Examiner

Funeral

Director

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23a

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Pages 1 and 2 If Health Item 27

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Maryland 21215-0020

Baltimore,

10/24/00 2:05 P.M.

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To the Hospital within 24 hours a To the Funeral D

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/Medical

10a. Stete

Director

Funeral

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Completed

Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last

SECTION OF ENFORCED SWALL BOWD SECOLO PROCEDURE TO RESECT SWILL BOWER (9/13/00

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes

COTORGE 25, 2000

1 Yes 2 No

25. Was case referred to medical 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 1D Yes 2 No 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work?

5 Pending investigation Netural 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of tnjury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted. 29a, Corffin

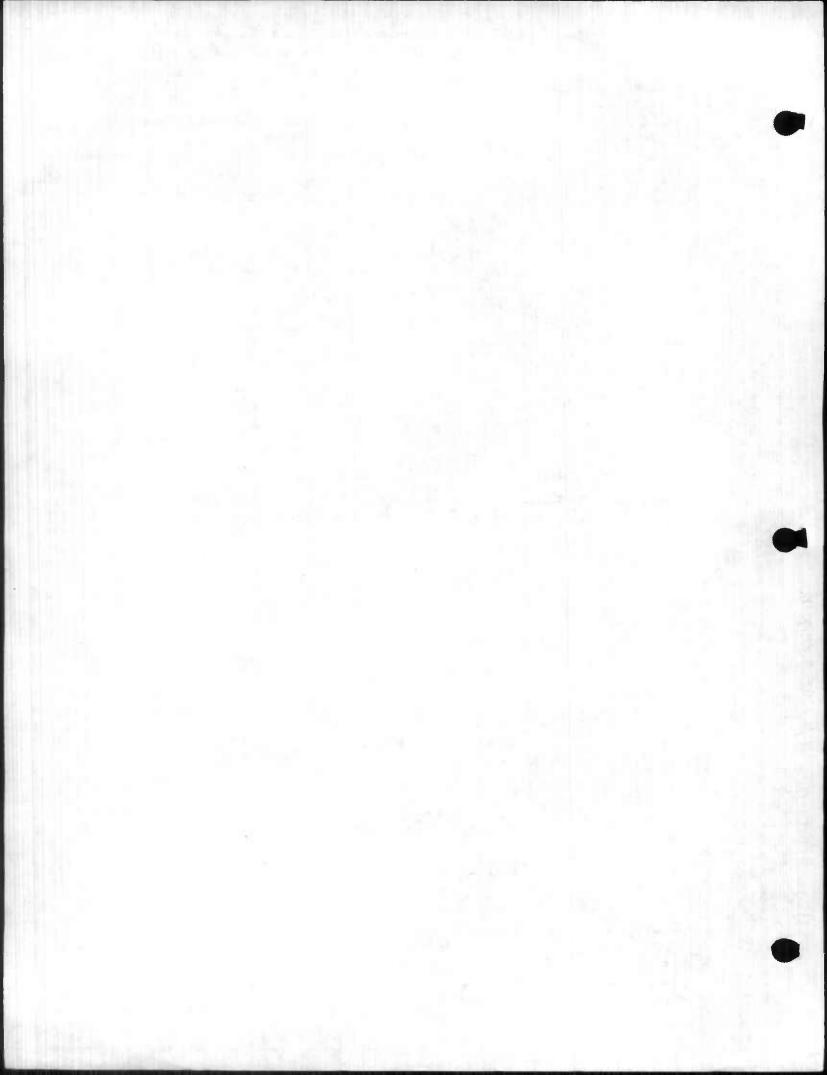
015234

29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ONE)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) BIKE, POCKVIUE, MO 20852

State Registrar 31. Date filed (Month, Day, Year) 3 0 2000 32. Registrar's Signature

mo.



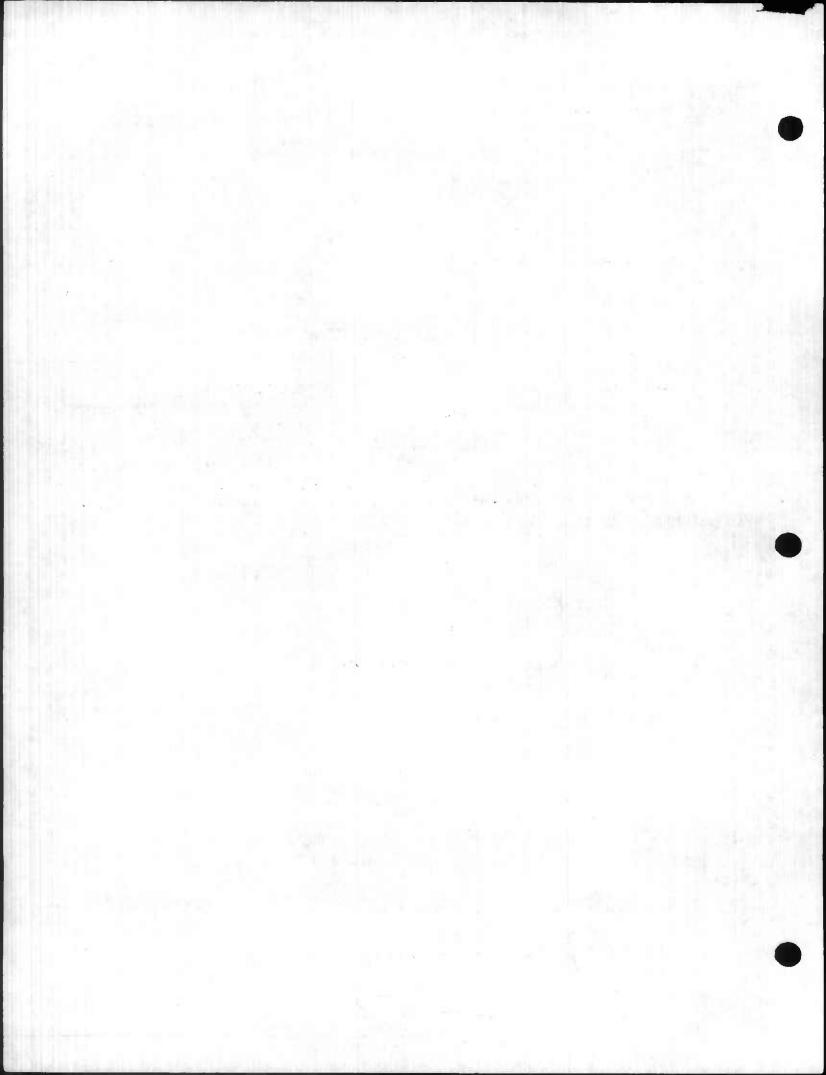
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State of Maryland / Department of Health and Mental Hygiene 0 36 1 19

Certificate of Death

Reg. No.

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ical	4a Facility Name (If not Institut				ille			4b. City. To	wn. or Lo	cation of Death			2025
iner				,017									
	Holy Cross Ho					l Milada	1 Van	Silver	Sp:	ring	Montg		
- 1	5. Social Security Number	6. Sex	M 2□ F 7	Age (In yrs.		If Under Months		Hours	Min.	8. Date of Bird (Month, Da	h y, Year)	9. Birthr	olece (Stete or
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-	Usuel Residence of Decedent			10- 00	. Tours and a								A. 1
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	resulting In death) Last		0									- 1	
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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Warner October 25, 2000 Physician Stanford Berman 9:50P. /Medical 4a Facility Nama (If not Institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 7429 Arrowood Road Bethesda Montgomery If Undar 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (Steta or Foraign Country) **Funeral** 1**X** M 2□ F Months Days 579-32-3462 72 June 22, 1928 Washington, D.C. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or larms 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Maryland Montgomery Bethesda Directo 2 10e. Sfreet and Number 10f. Zip Code 10g, Citizen of What Country? 7429 Arrowood Road 20817 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yas 2 No
ff Yes, Give
Year or Dates: Black, White, etc. hours after 1 Nevar Married 2 Married 1 Yes 2 No Specify. White Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation 2 (Give kind of work done during most of working life. DO NOT usa ratired) (Specify only highast grade completed) Med willhin Elementery/Secondary (0-12) College (1-4or 5+) Patent Lawyer Law 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Nama (First, Middle, Last) Be ahould be f marked Hyman Berman Ida Julia Koblen pue 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 at Department of Health and Important: If them 27 le n ÷ Marilyn Ruth Berman(wife) same as #10 Baltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cramation 3 ☐ Removal from Stata Adas Israel Cemetery 10/27/2000 4 ☐ Donation 5 ☐ Other (Specify) Washington, D.C. Donald V. Borgwardt Funeral Home, P.A. 21. Signature of Turnal Service Liquinsee 4400 Powder Mill Rd. Beltsville, Maryland 20705 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or near failure. List only one cause on each line. Approximate fnterval Between Onset and Deeth **Physician** fmmediete Cause (Final disease or condition resulting In death) /Medical B cell non hodgkins lymphoma Examiner Due to (or es e consequenca of): Examine attending physician and for use as the buriel-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avents resulting in death) Last Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or es a consequance of): requires that the death signed by the a 23b. Did tobacco use contribute to the cause of death? P.O. Pert ff. Other algniffcant conditions contributing to death but not resulting in the underlying cause given in Pert f. 1 Yes 20 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Were autopsy findings available prior to been sig 24e. Was en eutopsy performed? Completed completion of cause of death? The law page 2 certificate has 1 Yas 2 No 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatianf 2 ☐ ER/Outpatienf 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 2 After this funeral (28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury af Work? or Attending 5 Pending Investigation 1 Natural 1 Yes 2 No death. ours after death. 2 Accident 6 Could nof be determined 3 Suicida 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital
within 24 hours a
To the Funeral C 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier Cal (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies

State Registrar

DHMH 16 Rev 6/95

20

31. Dete filed (Month, Day, Year)

OCT

30 2000

32. Registrar's Signature

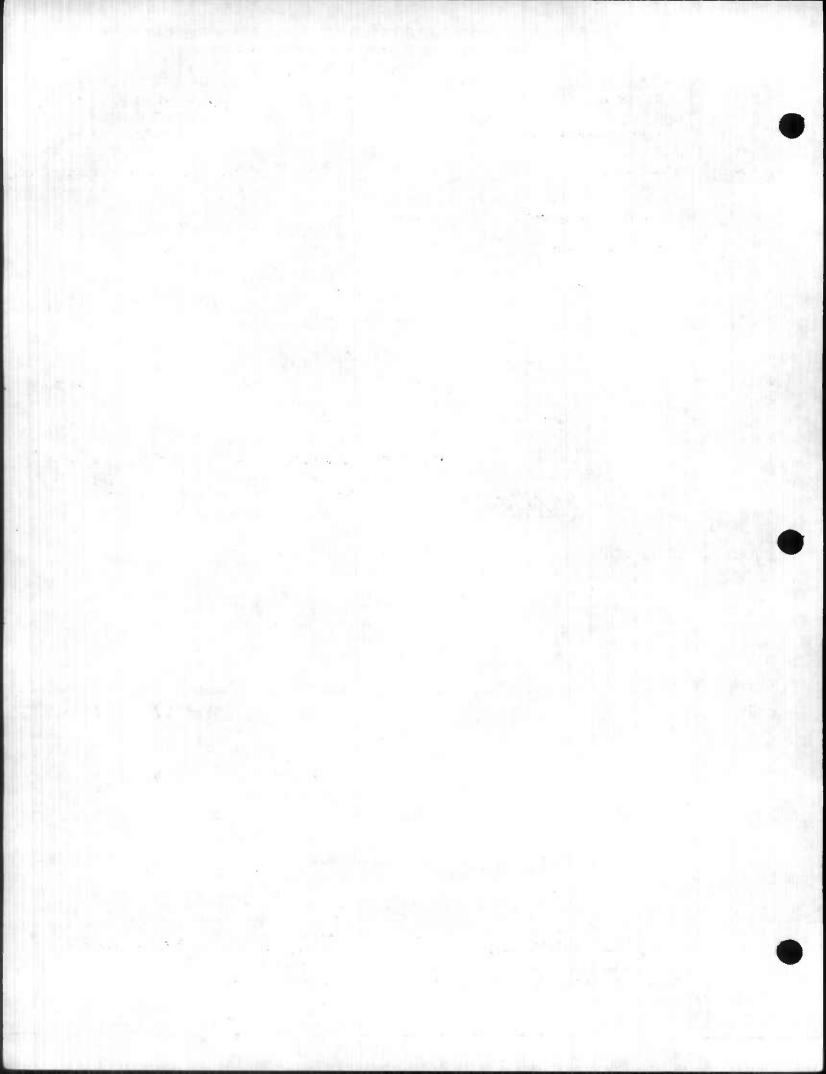
30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) C-2149 (2nd. Floor)

21030

October 26, 2000

ORIGINAL

Vera Malkovska, M.D. 110 Irving Street, N.W. Washington, D.C. 20009



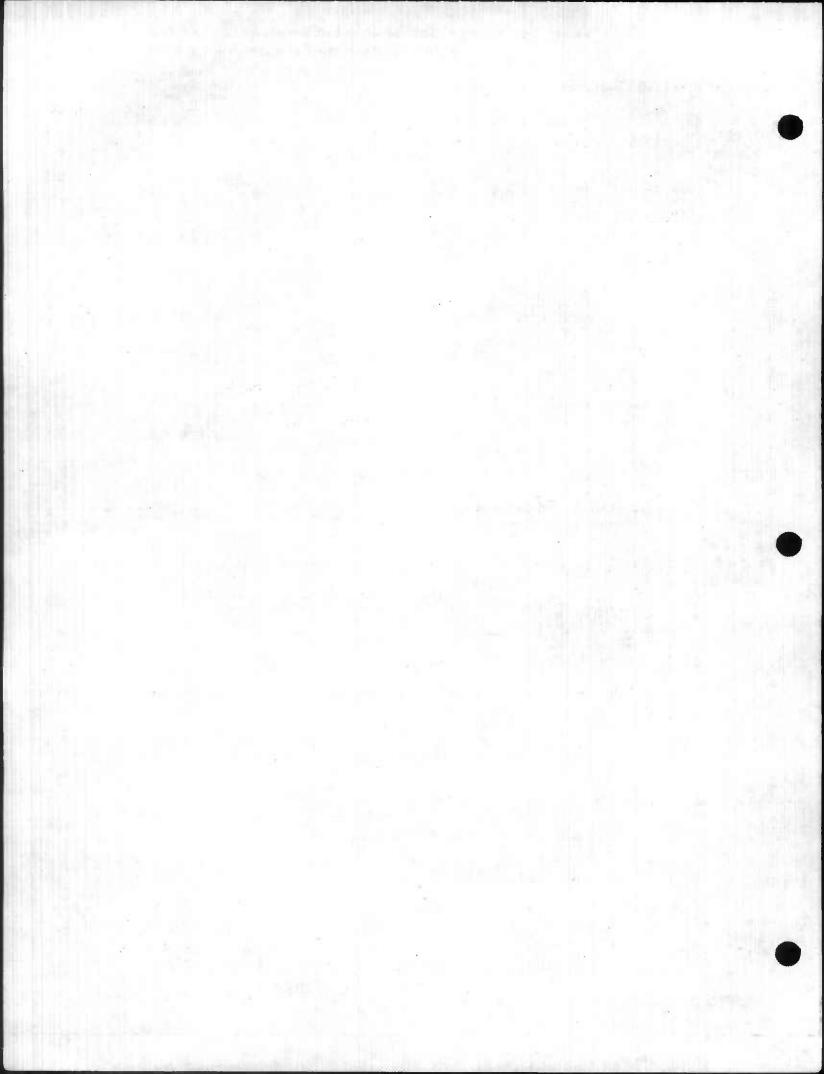
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State of Maryland / Department of Health and Mental Hygiene 0 36 | 2 |

				Ce	rtificat	e of	Death			Reg. No.	01	J 1 6. 1
	1. Decedent's Name (First, Mid	die, Last)	MANUAL PROPERTY.						2. Date of De		Maria	3. Time of Deat
nysician	Andrew		Bennett,	Tr					Octobe	Day r 26, 20	Year	8:45 P
Medical xaminer	4e Facility Neme (If not institut			-UL			4b. City, To	wn, or Lo	ocation of Deat			_0:4J_F1
Autilitie;	12505 Athert	on Drive					Whea	ton		Mont	gomen	***
al	5. Social Security Number	6. Sex	7. Age (In yrs. I	last birthday,		1 Year	If Under	24 Hrs.	8. Dete of Bir (Month, De	th .	9. Birthpl	ace (State or Ford ry)
r	578-26-6634	10XM 2□ F	79	Yrs.	Months	Deys	Hours	Min.		18, 1921		rvland
ı	Usual Residence of Decedent								Odilia	10, 1721	116	u y i and
	10a. State 10b. Coun	У	10c. City	y, Town or L	ocation						10	d. fnside City Lin
5	Maryland Mont	gomery	Whe	eaton								1 Yes 2
ire.	10e. Street and Number				10f. Ziç	Code				10g. Citizen of	What Count	iry?
JE D	12505 Atherto	n Dr.			20	906				USA		
Funeral Director	11. Marifal Status	12. Was De	ecedent Ever in U,	S. 13.			lispanic Or	igin? (Sp	ecify Yes or No Rican, etc.)		e - America	
F	1 ☐ Never Married 2 ☑ Me		Forces? s 2 No Give 1942-		ır yes, spe 1□ Yes	37			Hican, etc.)		ck, White, e	hite
þ	3 ☐ Widowed 4 ☐ Divorce	d Year or	Give 19427 Dates: 19427	6	1 LI Yes	2EFN0	Specify:			Specif	у:	
9	15. Decede	nt's Education		16a. Dece	dent's Usu	al Occup	ation	A - d ds		16b. Kind of B	usiness/Ind	ustry
Completed	(Specify only high Elementary/Secondary (0-12	est grade complete	d) (1-4or 5+)	life.	kind of wo DO NOT u	se retire	<i>auring</i> mos d)	it of work	ing			
EO	12	Comage	(1-40/04)	Pho	otogra	aphy				CIA- U	J. S.	Governme
Bec	17. Father's Name (First, Middle	, Last)					18. Mothe	er's Name	e (First, Middle	, Maiden Suman	ne)	
ToB	Andrew Bennet	t					Susa	ın Ha	11man			
	19a. Informant's Name/Relation	nship (Type, Print)	SHE TO	19b. Malli	ing Address	s (Street				er, City or Town,	State, Zip	Code)
	Louise I. Ber	nett/wife	2	1250	5 Ath	erto	n Dr.	, Wh	eaton.	Md. 209	06	
	20e. Method of Disposition		20b. P	lace of Disp	osition (Na	me of			Date	20c. Location		wn, State
	1 ☑ Burla1 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		m State	emetery, cre	•			1.1	0/21/0	П		
	21. Signature of Funeral Service		Fai	rfax	Memor 2. Name ei				.0/31/0) Fairf	ax, v	irginia
	21. Signature of Fundral Service	o Eroonsoo	0	-	2. 1401110 01	M	ONEY	& KI	NG VIE	NNA FUNE	RAL H	OME, INC
	nickard D	· tihora	ed			17	1 W	Man 1	e A170	Vienna		22180
ш	23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that st only one cause or	it caused the death n each line.	n. Do not en	ter the mod	de of dyir	ng, such as	cardiac	or respiratory a	arrest,		Approximate Interval Between
												Onset end Death
	fmmediate Cause (Final disease or condition	. Cer	rebrovasc	ular	Accid	ent						
	resulting in death)			r as a conse							1	- No. 1
Examiner		Art Art	eroscler	otic	Cereb	rova	scula	r Di	sease		i	
cam	Sequentially list conditions,			r as a conse								
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											
edicai	that initiated events	6.	Due to (or	r as e conse	quence of):							
2												
Physician/		0										
sici	Part II. Other significant condi	tiona contributing to	death but not resu	ulting in the u	underfying	cause giv	en in Part	f.	23b. Did	tobacco usa co	ontributa to	the cause of de
E .	Alzheimer's I	ementia							1□	Yaa 2XNo	3 Prot	eably 4 Unkr
DY -	- I E I E I E E E E E E E E E E E E E E	Calcutta										
Completed by	Coronary Arte	rv Diseas	20						24a. Was	s an autopsy ormed?	24b. We	ere autopsy findin allable prior to
olet		2) 323045							pon	01111001	COL	nplefion of cause death?
E									10	Yes 20 No	10	Yes 2□ No
	25. Was case referred to medic	al l		_			OF Plan	a of Dool	th (Check only		1	7163 20160
o Be	examiner?	Hospital:	The second of	FD/0	-1 2 0	Oti		-		idence 6 Ott	(0	.i
0 :	27. Manner of Death			ER/Outpatie		07	4014	ursing Ho		how Injury occu		()
0	1 ☐ Natural 5 ☐ Pend	ling (M	te of Injury onth, Day Year)	fnjury	м	28c. fnju Wo	rk? Yes 2□	No				
Certification:	3 Suicide 6 Coul	nof be	oo of lainer. At he	omo form of					28f Location	(Street and Num	her or Rure	l Route Number
ŧ	4 ☐ Homicide dete		ice of Injury - At ho ilding, etc. (Specif)	y)	ileer, lactor	y, omce			City or To	wn, State)	DOT OF FIGURE	Triodio Italicoi,
edical	29a. Certifier t☑ Certify (Check only 2 Medic	ing Physician: To t il Examiner: On the	he best of my know Leasts of examinat	wledge, deal tion and/or Ir	th occurred ovestigation	at the ti	me, date ar opinion, dea	nd place, ath occur	and due to the red at the time	cause(s) and m , date and place,	anner as st , and due to	ated. the cause(s)
Med		1	nhner stated.									
-	29b. Signature and Atle of certif				29		se number			29d. Dete signe		
	I mel	1/1/	1 .1	70		D03	792		K	October	26, 2	000
	30. Name and address of perso	n who completed ca	use of death (Item	23a) (Type	, Prinf)		UE		-			
	10301 Georgi	a Ave S	Silver Sp	ring.	Mary	land	2090	2				
ite	31. Date filed (Month, Day, Yes		Registrar's Signa		-					1 1		
rar	OCT 3	2000	Mura	19.	do	aks	1					

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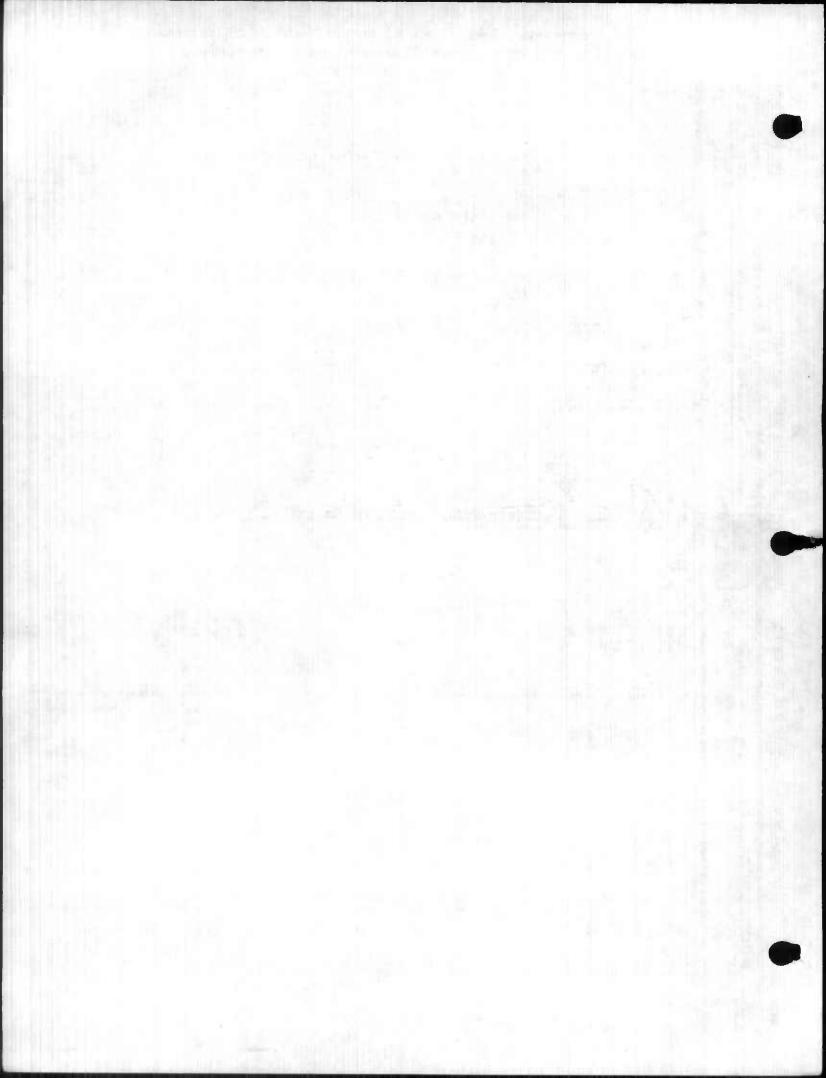
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State of Maryland / Department of Health and Mental Hygiene 00 36 | 22

				Ce	rtificat	e of	Death			Reg. No.			
	1. Decedent's Neme (First, Middle			J					2. Dete of De			3. Time of Death	
Physician		Anna L	ouise l	Berg					Octobe	r 31, 2	000	4:15 AM	
/Medical	An Control of the same of the same to national and	n, aive street and nur	mber)				4b. City, To	wn, or L	ocation of Deat				
Examiner	Montgomery Hosp						Rock				gome		
	5. Social Security Number	6. Sex	7. Age (In yrs.	last hirthday	If Under	1 Year	If Under	24 Hrs.	A Date of Bir			place (Stete or Foreign	
Funeral	235-30-2586	1□M 2ŒF	7. 790 (111)/3.		Months	Days	Hours	Min.	8. Dele of Bir (Month, Da Nov . 5,	y. Year) 1	West	Virginia	
Director	Usual Residence of Decedent								,	1,21	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1218	
B 1.	10a. Stete 10b. County		10c. Ci	ity, Town or Lo	ocation						1	10d. Inside City Limits	
de de la constante de la const	Maryland Mont	gomery		Rock	ville							1⊠ Yes 2□ No	
of the Ma	10e. Street and Number				10f. Zip	Code			7	10g. Citizen of	What Cou	ntry?	
1 9 M		Arronile			Toil Zip		0851			United		*	
Of the Maryland that death with the Maryland that death with the Maryland the tributed at Europe of Director	1/04 Gluenchel		4 4 5 - 1 4	10 10	144 5			1-0 10-	a sida. Waa aa Nis			can Indian,	
	11, Meritel Stetus	Armed Fo		J,S. 13.	If Yes, spec	cify Cub	an, Mexicar	gin / (Sp n, Puerto	ecify Yes or No Rican, etc.)	Ble	ck, White,		
		If Yes, Giv	ve ev		1 ☐ Yes	2 🔯 No	Specify:			Specify	y: W	hite	
hours after hours after hurst, or its at Examina		Yeer or D	ates:	100	4 4 4					405-161-4-4.0		4.4	
21215-0 ed within 72 ho yglere. we then "natur it, the Medical.	15. Decedent (Specify only highes			(Give	dent's Usua kind of wo DO NOT us	rk done	duning mos	t of worl	ing	16b. Kind of B	usiness/in	dustry	
within the same	Elementary/Secondary (0-12)	College (1	1-4or 5+)							Doctor	te n	ffice	
D STATE OF S		4		Kegi	stere	u Nu		odo Nam	- /Cinct Afieldto			11100	
Maryland 21215-0020 d 2 should be filled within 72 hours at th and Mental hygiene "natural", or fris meriod other than "natural", or fraumetic event, the Medical Exam To Re Completed by	17. Father's Name (First, Middle,								Bird	, Maiden Suman	ne)		
yie whee	•		/										
As 2 sah	19a. Informant's Name/Relations									er, City or Town,			
- 5304	Henry J. Ferry/	Nephew	- Inches				Plac					land 20903	
Or of the state	20a. Method of Disposition 1	3 DRemovel from	Cinto	Plece of Disponent cemetery, cre	metory or o	ther ple		1	Nov. 3,	20c. Location			
Pages Nacot of Intelligible			Pa	rklawn	Memo	rial	Park		2000	Rockvil	le,	Maryland	
Saltimore semit. Pages 1: separtment of He reportant if her my injury or oth rise.	4 Donation 5 Done (Specify)												
0 18118	MOO198 300 West Montgomery Avenue												
	M00198 300 West Montgomery Avenue Rockville, Maryland 20850-2805 23e. Pert 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate												
	shock, or heart feilure. List	only one cause on e	ech line.			,						Intervel Between Onset and Death	
Physician // // // // // // // // // // // // //	Immediate Cause (Finel	0	1 1	37 1	A -							4 weeks	
Examiner	diseese or condition resulting in death)	a. Cer	rebral	vascui	ar Ac	clae	ent					4 WEEKS	
				or as a conse	quence of):						1		
pa isit		b. Hyp	pertens	ion							i	years	
58760, cate be executed physicien and s the buriel-transit	Sequentially list conditions, if any, leading to immediate		Due to (or es e conse	quence of):						i		
68760, filcate be ex physician as the burial	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	C									i		
6876C	thet initieted events resulting in death) Last		Due to (d	or as e conse	quence of):								
Find Partition		d									i		
P.O. BOy et the death of d by the attend etached for us		<u> </u>											
- 0 0 0	Part II. Other significant condition	ens contributing to de	eath but not res	sulting in the u	underlying o	ause gi	ven in Part i	1.	23b. Dld	tobacco usa co	ontribute i	to the cause of death?	
Physical Physics of Ph									1 🗆	Yes 2 No	3 Pro	obably 4 Hunknow	
Cords, requires been sign should be									24a. Wes	an autopsy	24b. W	Vere sutopsy findings vailable prior to	
ecor lew requi											C	ompletion of cause f death?	
The lew requirements that the lew requirements to be a should Completed									10	Yes 2K No	1	☐Yes 2☐No	
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of Vitai Records, Physicien: The lew requires the this certificate has been signeral director, page 2 should be completed by		28a. Dete	Inpatient 2	J ER/Outpatie		JA	4 🗆 140	ursing H		how injury occur		Hospice	
SION O sending Ph eeth. or: After th the funeral	1 ☑ Netural 5 ☐ Pendin	g (Mon	th, Day Year)	Injury	М	28c. Inju Wo	rk? Yes 2 🗆	No	200. 2000100	non injury cood			
VISION Attending or deeth. ector: Afte by the fune	2 ☐ Accident Investig	nol ho	-48-1 44.5				1 105 2	140	204 Location	Ctroat and Alum	has as Du	rel Route Number,	
Division of Balanding P as after death. In Director: After the in by the funeration:	4 ☐ Homicide determ	ined 286. Placa	of Injury - At hing, etc. (Speci	ify)	reet, rector	y, orrice				wn, Stete)	Der Or Hur	or rioute regimber,	
Ne Hospital n 24 hours a ne Funeral i pletely filled	29e. Certifier 1 ☐ Certifyin (Check only 2 ☐ Medical)	g Physician: To the Examiner: On the ba	asis of examine										
within 2 To the complex			ner steted.		100					004 0	-1 (0.4 1)	O	
To Too	29b. Signature and little of certifie	0.0			296		se number			29d. Dete signe			
12	100	Lebre	N	D.		D	09470			October	r 31,	2000	
	30. Name and address of person												
	Eugene P. Libre	, M.D. 1	0400 Co	nnecti	cut A	ven	ue, Ke	ensi	ngton,	Marylan	d 208	395	
State	31. Date filed (Month, Dey, Year)		egistrer's Sign		-								
Registrar	NOV 03	2000	Meren	Ø.	po	al.	2						
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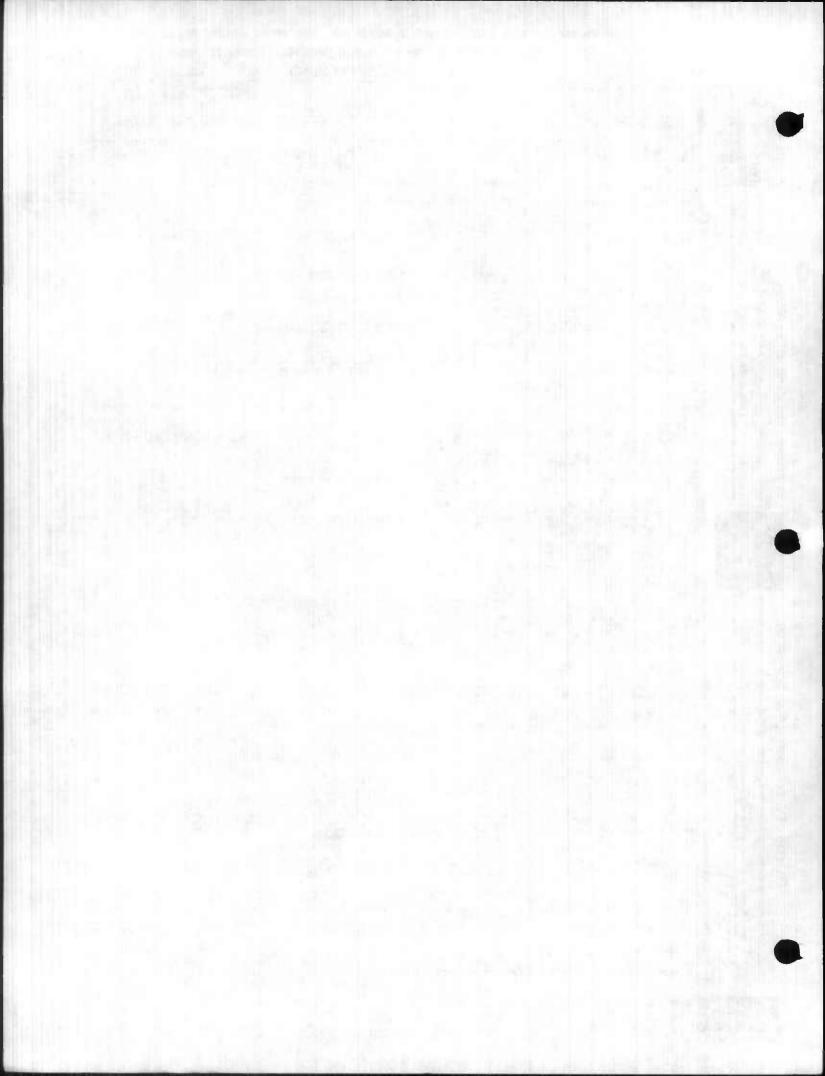
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State of Maryland / Department of Health and Mental Hygiene 0 0 36 | 23

Certificate of Death

Reg. No.

ian cal								Reg. N			
_	1. Decedent's Neme (First, Midd	le, Last)					2. Date Mor	of Deeth	өу	Yaer	3. Time of De
	ARLENE	JOAN	BELA	ASCO			OCTO		, 200	00	7:40 P
	4e Facility Nama (If not institutio	n, giva street end num	ber)			4b. City, To	wn, or Location o	f Death 4	c. County	of Deeth	
101	SHADY GI	ROVE ADVE	אידכי ו	IOSPI	TPΔT.	ROC	CKVILLE	,	MON	TGOME	PDV
	5. Social Security Number	, , , , , , , , , , , , , , , , , , , ,	. Aga (In yrs. last		If Under 1 Ya	ar If Undar	24 Hrs. 8 Date	of Birth			e (Stete or Fo
	102-52-4022	1□M 2□F	44	Yrs.	Months Da	/s Hours		18, 19		New Yo	
+	Usuai Residence of Decedent			-			ITED	10, 1.	,,,,,	14CW 10	, I IC
-	10a. Stata 10b. County	,	10c. City, T	own or Loc	ation					10d.	Inside City L
	Maryland Mont	gomery	Co	rmant	orm.						1 Yes 25
1	10e. Streef end Number	gomery	Ge.	Imanic	10f. Zip Cod	9		100.0	itizen of W	hat Counfry	>
5		0			2087					State	
	19228 Deep Run			1 40 10			-i-0 (Casalfa Va			- American	
	11, Merifal Status	Armed Ford	dent Evar in U,S.	13. W	Yes, specify C	uban, Mexicer	gin? (Specify Yas n, Puerto Rican, e	itc.)		k, Whita, etc.	
	1 Never Merried 2 Mer	If Yes, Give	ZIAINO	1	☐ Yes 2 🕅 I	lo Specify:			Specify:	w 94	
	3 Widowed 4 Divorced	Yeer or Dat									ite
	15. Deceder (Specify only higher	nt's Education est grade completed)	1	6a. Decede (Give k	ent's Usuel Oc	cupation ne during mos	t of working	16b.	Kind of Bu	siness/Indus	try
	Elementery/Secondery (0-12)	College (1-	4or 5+)	life. D	O NOT use rel	ired)		D			II. a 1 to
-	12			Healt	h Room	_					Healt
	17. Father's Name (First, Middle,	Last)					er's Neme (First,				
	Arthur	Hessel				Joa	n	M	linges	3	
1	19a. Informant's Neme/Reletions	ship (Type, Print)		19b. Mailing	Address (Str	et and Numbe	er or Rurel Route	Number, City	or Town,	Stete, Zip Co	ode)
	Peter Belasco,	Husband		19228	Deep I	Run Cou	rt, Gen	mantow	m, N	D 20	876
1	20a. Method of Disposition			_	ition (Neme of atory or other		Dete		Location - (City or Town,	Stete
ı	1 Buriel 2 Cremetion		1616				Nov 3		,		
-	4 Donetion 5 Other (S	• • • • • • • • • • • • • • • • • • • •	Metr	-	tan Cre) Ale	xandı	ria, V	A
+	21 Signature of Funerel Servica	Licensee	00	22.	Neme end Ad	oress of Facilit	DeVol	Funer	al Ho	ome	
	Micha	well	Melse				Dr., Ga		burg	, MD	20877
	23a. Pert1. Enter the diseasa, or shock, or heart feilure. List	r complications that car	used the death. [Do not ente	r the mode of	dying, such as	cardiec or respir	etory errest,		Ar	proximete tervai Betwee
										Or	nset end Dea
	Immediate Ceuse (Final disease or condition	TMTRA	CRANIAL	нем∩в	RHACE					2	HOURS
	resulting in death)	a. IIIII	Due to (or es							1	
DI III		NON C	MALL CEL			OF LUN	IG			6	MONTH
		b. NON SI				OI DON		_		1	1101(11
	Sequentially list conditions, if any, leading to immadiate causa. Enter Underlying	100	Dua to (or as	s a consequ	Jenca oi):						
	causa. Enter Underlying	с									
	Cause (Disease or injury		Dua fo (or as	a consequ	ance of):						
Z	thet initieted events resulting in death) Last									1	
	Cause (Disease or injury	d								1	
2	Cause (Disease or injury	d								1	
\$	Cause (Disease or injury	d	ath but not resultin	ng in the un	derlying cause	given in Pert I	1. 23	b. Did tobacc	o uss con	tributs to th	e cause of c
Physician/M	Cause (Disease or Injury thet initiated events resulting in death) Last			ng in the un	derlying cause	given in Pert I	1. 23	b. Did tobacc			
by Physician/Me	Cause (Disease or injury that initiated events resulting in death) Last			ng in the un	derlying cause	given in Pert I	l. 23				e causs of d
Dy Filysicialum	Cause (Disease or injury that initiated events resulting in death) Last			ng in the un	derlying cause	given in Pert I		1 Tes	2 No opsy	3 Probet	eutopsy find
	Cause (Disease or injury that initiated events resulting in death) Last			ng in the un	derlying cause	given in Pert I		1 Yes	2 No opsy	3 Probet	eutopsy find bie prior to letion of caus
	Cause (Disease or injury that initiated events resulting in death) Last			ng in the un	derlying cause	given in Pert I		1 Yes a. Was an aut performed?	2₩ No opsy	3 Probeb 24b. Were availa comp of dea	eutopsy find bile prior fo letion of causath?
	Cause (Disease or injury that initialed events resulting in death) Last Pert II. Other algnificant conditions are supported to the support of the support o	O BONE & B		ng in the un	derlying cause		24	1 Yes a. Was an aul performed?	2 No opsy	3 Probeb 24b. Were availa comp of dea	eutopsy find bie prior fo letion of caus
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to position of the second of t	25. Was case referred to medica exeminer? 1 Yes 2 No 27. Manner of Death 1 1 1 1 1 1 1 1 1	Hospitel: 1 🕍 In (Month)	RAIN	/Outpatient	3 DOA 28c. (26. Plece Other: 4 No	e of Deeth (Checursing Home 5 (28d. De	1 Yes a. Was an autoperformed? 1 Yes k only one) Residenca scribe how in	2 No opsy 2 No 6 □Othe	3 Probab 24b. Were availar comp of dea 1 Year (Specify)	eutopsy finc bile prior fo letion of cau ath?
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36124 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 1, NOV. 2000 2:30 PM ROY E. BEAUJEAN /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SEMINARY PL. 1959 SILVER SPRING MONTGOMERY Hours Min. 8. Date of Birth (Month, Dey, Year) If Under t Year 5. Social Security Number 6, Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days tXM 2□F Months 65 MICHIGAN Director 375-32-3324 Usual Residence of Decede the Manyland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits than "natural, or items 23a or 28a-f ahow the Medical Examiner must be notified at Director 1X Yes 2 No MONTGOMERY SILVER SPRING MD. 10e Street and Number 10f. Zip Code t0g. Citizen of What Country? 1959 SEMINARY PL. 20910 U.S.A. Funeral t2. Was Decedent Ever in U,S. Armed Forces? 1 121 Yes 2 1 No 1 Yes, Give Year or Dates: 1 057 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 N Married "naturel", or Baltimore, Maryland 21215-0020 t ☐ Yes 2 No Specify: PV 3 ☐ Widowed 4 ☐ Divorced WHITE 1957 Completed t 6a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) t5. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry sel Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ENGINEERING 2 **ENGINEER** permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: If Nem 27 Ie marked othe eny Injury or other traumatic event, phos. 17. Father's Name (First, Middle, Last) t8. Mother's Name (First, Middle, Maiden Sumame) Be EMIL BEAUJEAN ANDERSON MYRTLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) ELLEN D. BEAUJEAN/WIFE SAME AS ITEM #10 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removal from State Nov. 2,2000 RIVERDALE, MD. 4 Donation 5 Other (Specify) CHAMBERS CREMATORY 21. Signature of Funeral Service Liceon 22. Name and Address of Facility 20906 rambused M00091 CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** immediate Cause (Final disease or condition resulting in death) /Medical ACUTE MYOCARDIAL INFARCTION 4 MIN. Examiner Due to (or as a consequence of): Examiner 2 YRS. CORONARY ARTERY DISEASE attending physician and for use as the burlei-transit certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 68760. Physician/Medical Due to (or as a consequence of): 1 Box signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown OBESITY Records. p 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed

HYPERTENSION

25. Was case referred to medical 1 Yes 2 No 27. Manner of Death

> 1 Matural 5 Pending investigation 2 Accident 6 ☐ Could not be 3 Suicide 4 Homicide

Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Date of Injury (Month, Day Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 1 Residence 6 Other (Specify)

t 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

1 Yes 2 No

28d. Describe how injury occurred

29b. Signature and fills of certifier lu

022309

29c. License number

28c. tnjury at Work?

2000

1 Yes 2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PHILLIP W. POTH. M.D. 31. Date filed (Month, Day, Year)

2000 NOV 03

32. Registrar's Signature Beneva

9013 FLOWER AVE., SILVER SPRING, MD. 20901

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Director:

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Certification:

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29a. Certifier

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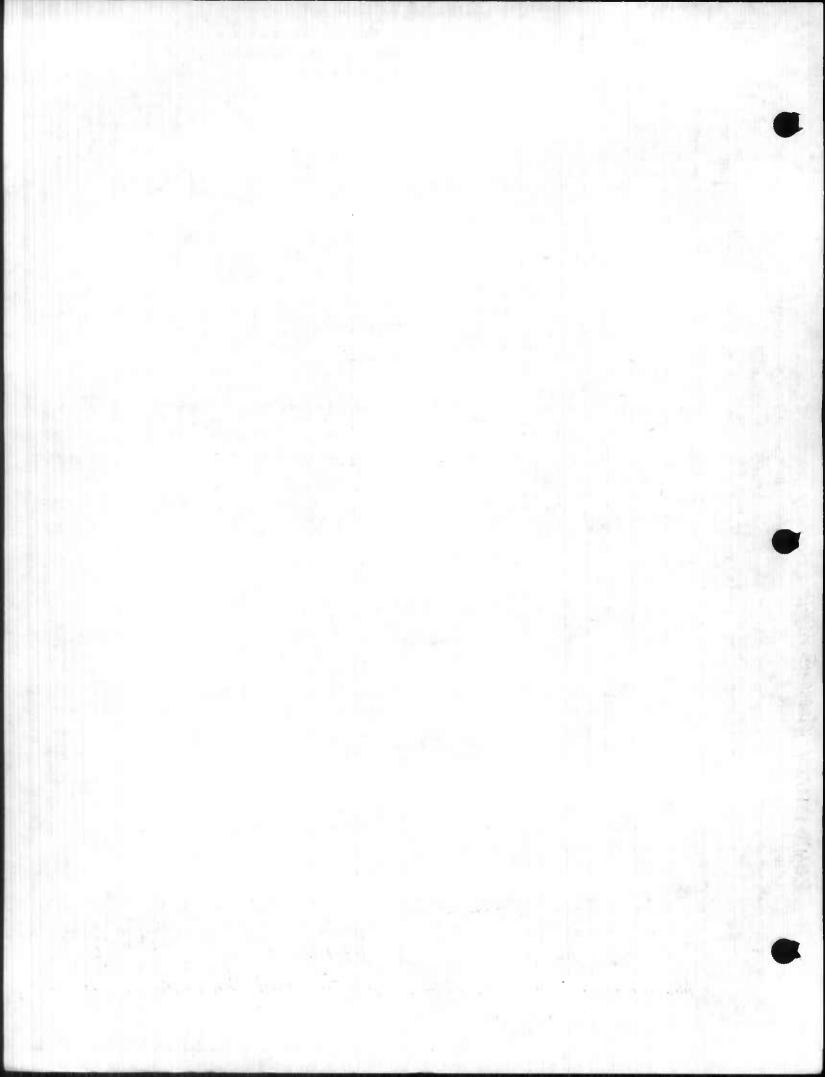
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State of Maryland / Department of Health and Mental Hygiene

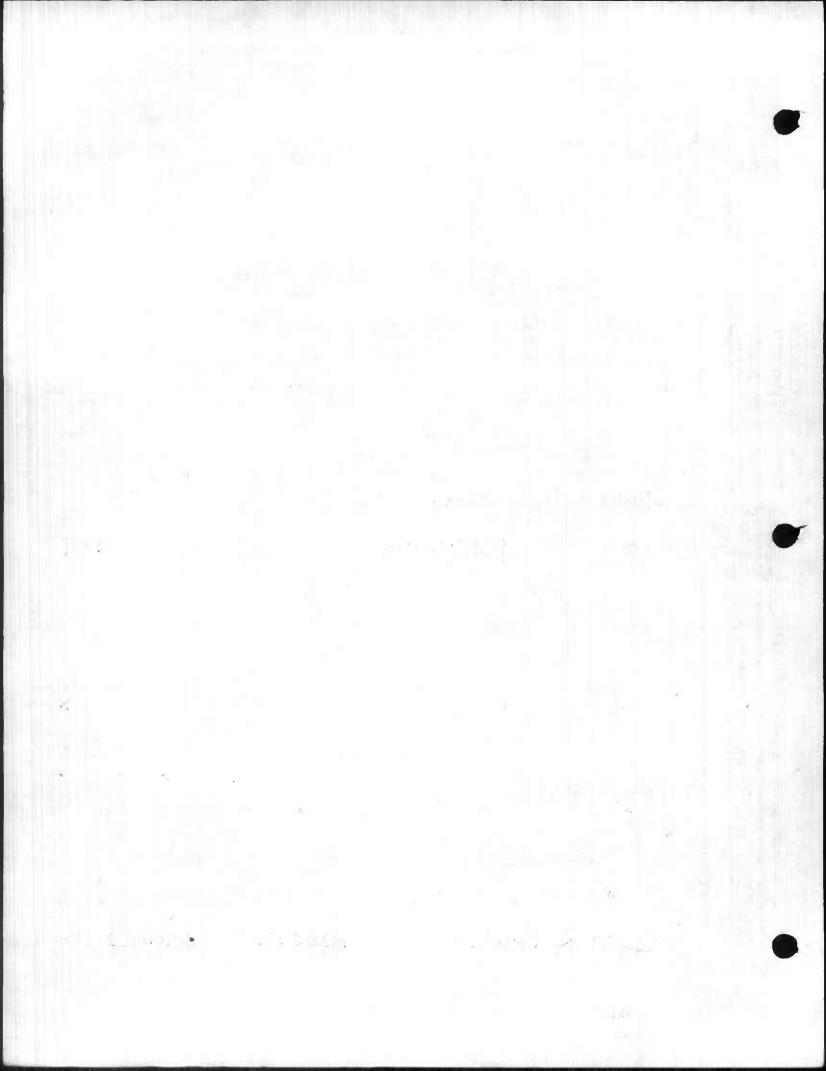
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Physician /Medical	MARY A	LICE BEAN	IDER				OCT.			:12 P
Examiner	4a Facility Name (If not institution	n, giva street and number)			- 4	b. City, Town, or	Location of Death	4c. County	of Death	
THE RESERVE	Suburban Ho	spital				Bethes	đa	MON	TGOME	RY
Funeral	5. Social Security Number	6. Sex 7. Ag	e (In yrs. last bi		er 1 Year S Days	Bethes If Under 24 Hrs Hours Min	8. Date of Birt	h Yearl		(State or Fore
Director	215-36-5493 Usual Residence of Decedent	1□M 2XIF	80	Yrs.	Days	(Notes Will)	8. Date of Bird (Month, Da July12	,1920	Mar	yland
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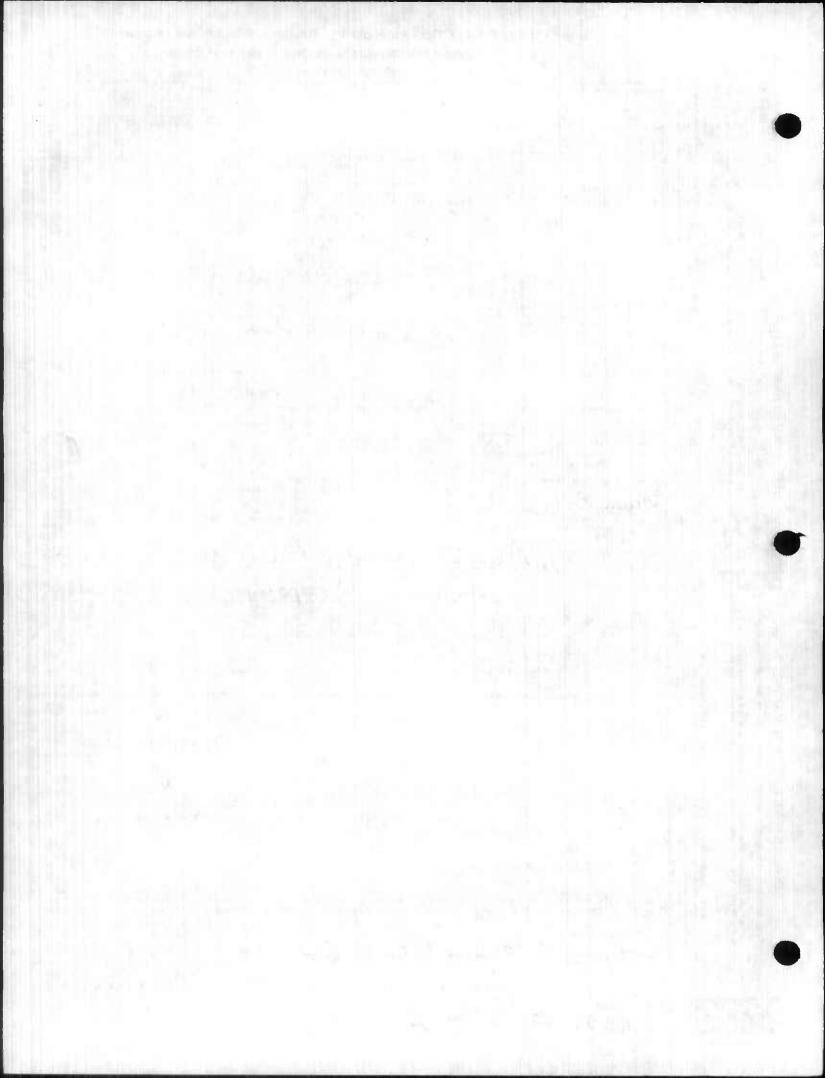
State of Maryland / Department of Health and Mental Hygiene 36

				Certific	ate of	Death		Reg. No.	36126
Physician	Decedent's Neme (First, Middle,	Last)					2. Date of De Month	ath Dey	3. Time of De
/Medical	Anastasia	Вах	evanis				Octobe	-	5:00
Examiner	4e Fecility Neme (If not institution,	ive street and number)				4b. City, Town, or	Location of Death	4c. County	of Death
" I L	Mariner Health	Care				Bethesda		Montgo	mery
Funeral	5. Social Security Number 6		e (In yrs. last birt	thday) If Ur Mont	nder 1 Year ths Days			h v. Year)	Birthplace (Stete or For Country)
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octo din	Maryland Montgom	ery	Bethes						I les Vi
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un aher death af, or hama 23 Examiner must by Funeral	1 Never Merried 2 Merried 3 Widowed 4 Divorced	Armed Forces?			specify Cub s 2XXVo	Hispanic Origin? (: ean, Mexican, Puer Specify:	no Rican, etc.)	Specify:	White
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CHNE	Andreas Baxevani	S	10.	503 Gr	ove R	idge Pla	ce, Beth	esda, MI	20852
mil. Pages 1 a partment of Hei portant. If then y injury or othe	20a. Method of Disposition		20b. Plece of	Disposition (Neme of	ice)	Dete	20c. Location -	City or Town, Stete
Page Page Try or III	WXBuriel 2 □ Cremation 3 4 □ Donetion 5 □ Other (Spe		Greenf				11/2/00	Uniondal	o MV
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se od os	Part II. Other significant conditions	contributing to death be	ut not resulting in	the underlyir	ng cause gi	ven in Part I.	23b. Did 1	obacco use cor	tribute to the cause of d
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								an autopsy med?	24b. Were autopsy find available prior to completion of cause
The law requir									of death?
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sician: The certificate lirector, pag o Be Co	25. Was case referred to medical examiner?	Hospitel:			100		eth (Check only o		
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tal or Attending P is after death. of Director: After is in by the funers Certification:	FEET PAUL III								A CHARLES
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Vithin Vithin Your Management of the Within Ma	29b. Signature and title of certifier	0			29c. Licen			29d. Date signed	(Month, Day, Year)
/	1 (rabble A	- Krill	THE PARTY OF		3	30692		Octobe	12 30, 200
5	20 Name and address			Towns Collection					
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	Gabriel A. Berr 31. Dete filed (Month, Dey, Year)		13223 S. ar's Signature	nady G	rove	NUAD, #3	os, kock	ville, M	ע 20030
State Registrar	MOV R 9		pas L	5. A.	20cks				



State of Maryland / Department of Health and Mental Hygiene 0 0 36127

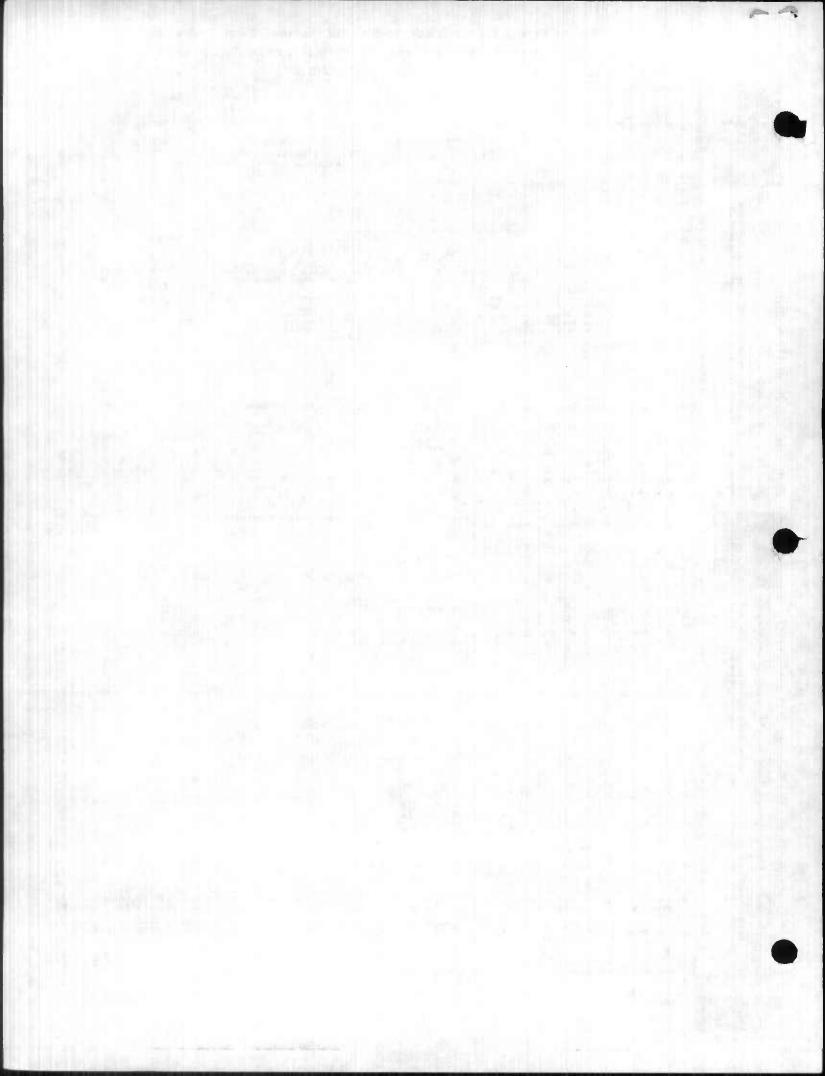
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/Medical Examiner	4a Facility Name (If not institution, give Genesis Elderca				4			eation of Death Park	4c. County	of Death	ndel
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o distanta	Cyrus Bassler					Carı	rie I	Langfor	d		
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od 2	Joyce C. Bernar	d-Daughter	33	Thomas	Rd	. Gler	n Bur	nie. M	D 21060		
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Page ment of ant: If I	1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Othar (Specify			itan C			10	0/31/00	Alexa	ndria	, VA
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State of Maryland / Department of Health and Mental Hygiene

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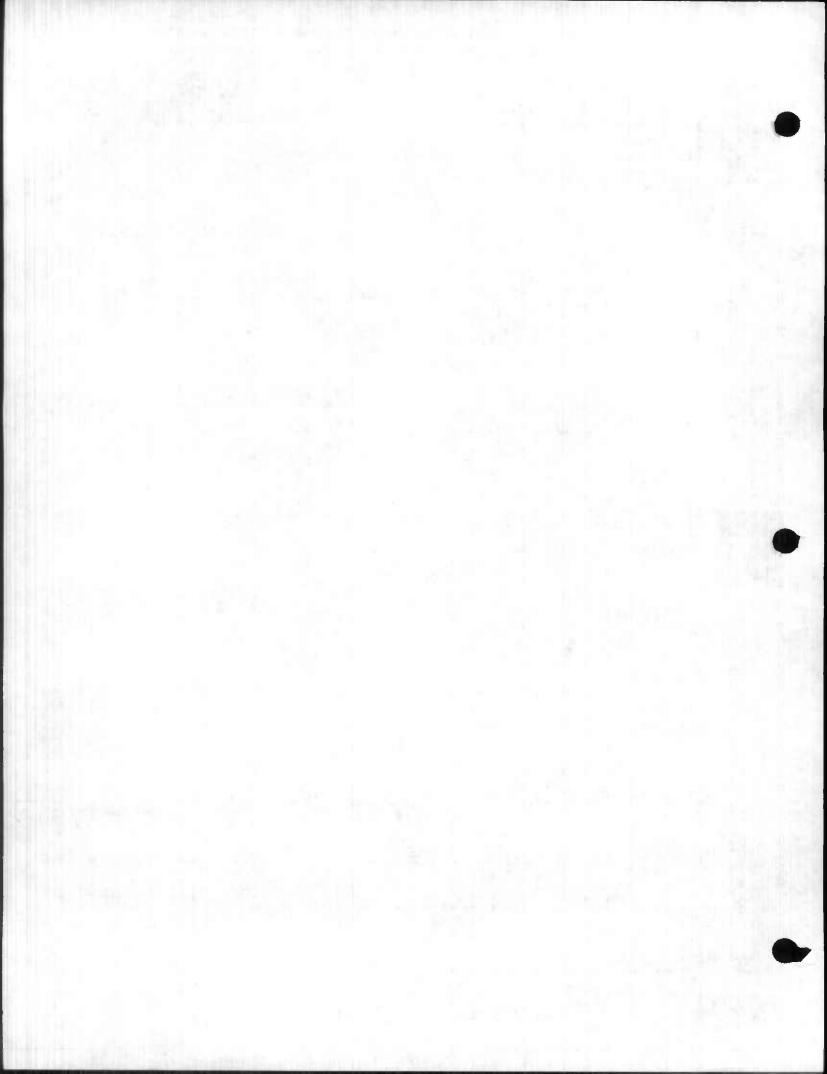
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State of Maryland / Department of Health and Mental Hygiene 1

					Certificate of		Re	g. No.))	0129
	Physician	1. Decedent's Name (First, Middle,				1	2. Date of Death Month	Day	Year	3. Time of Death
	/Medical				Bowie, Sr.		October	17, 2	000	2:00 P.M
	Examiner	4a Fscility Name (If not institution,				4b. City, Town, or I		4c. County o		
		Frederick Men 5. Social Security Number		spital ge (fn yrs. lest birt	hday) If Under 1 Ye	Frederi ear H Under 24 Hrs.		Frede		(Channe Carrier
L	Funeral Director	432-30-8121 Usual Residence of Decedent	10XM 2□ F		rrs. Months Da		(Month, Dey, 1	Year)	_	ce (Stete or Foreign) MD
	M M	10a. State 10b. County		10c. City, Town	or Location				10d	. Inside City Limits
	to it	MD Freder	rick	Barto	nsville					1 ☐ Yes 2 No
	23a or 28a-f si the nonfred al Director	10e. Street and Number 5947 Bartonsv	ille Road	i	10f. Zip Coo 217			g. Citizen of W		?
21215-0020	os illed within 72 nouts after ceant with the waryand tel Hygiene. Iel Hygiene d'other than "natural", or items 23a or 28a-f show evant, the Medical Examinar maint be noutred at Search than the Completed by Funeral Director		12. Was Deceden Armed Forces d 1 Yes 2 If Yes, Give Yeer or Dates:	?	13. Was Decedent If Yes, specify 0 1 ☐ Yes 2 ☑	of Hispanic Origin? (S Cuben, Mexican, Puerl No Specify:	pecify Yes or No- o Rican, etc.)	Black	- American , White, etc Blac	D
5-0	od within 72 hours or ygiene. Not than "natural", of the theory of the	15. Decedent's (Specify only highest	Education grade completed)	16a.	Decedent's Usual Oc (Give kind of work do	cupation one during most of wor tired)	king 1	6b. Kind of Bus	iness/Indus	stry
121	OF COL	Elementary/Secondary (0-12)	College (1-4or		ille. DO NOT use re eacher	tired)		Schoo	.1	
7	S S S S S S S S S S S S S S S S S S S		Masters I	eg.	acher	18 Mother's Nar	ne (First, Middle, Mi			
		Emanus Calumbu					Ellen Th		,	
7	and Men le marke reumatic	19a. Informant's Name/Relationshi		19b.	Maiting Address (Str	reet and Number or Ru			State, Zip Ci	ode)
	Heelth ar bm 27 Is ther trau	Byron Bowie (59	947 Barto	onsville	RdBar	tonsvi	ille.	21704 MD
ore,	of Heelt of Heelt f hem 27 r other	20e. Method of Disposition		20b. Pleca of	Disposition (Neme o			Oc. Location - C		
mo	mt: If he	1 Burial 2 Cremation 3 4 Donation 5 Other (Spe		9	nsville		10-24-00	Bart	onsvi	ille,MD
	permit, reges I end Department of Heelth Important: if item 27 any injury or other ti 2005.	21. Signature of Funeral Service Li	Collin		22. Name end Ad					21701
		23a. Pag. Enter the disease, or c shock, or heart liture. List of	mplications that cause	ed the deeth. Do n						pproximate nterval Between
1	hysician /Medical	Immediate Cause (Final disease or condition	a. Myoc		INPARCO				O	Diset and Death
	xaminer	resulting in death)		Due to (or as a c					-	
7	i ii		B. PNEUM	とってって			1.074	11-5	5	LYACI
60,	g physician and ss the burial-transit	Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	c	Due to (or as a c	onsequence of):				1	
		resulting in death) Last	d	Due to (or as a c	onsequenca of):					
O. Box	0 0 0	Part II. Other significant condition	s contributing to death	but not resulting In	the underlying ceuse	given în Part I.				he causs of death?
P.0	ed by detac						1 🗆 Ys	8 2□ No	3 Probai	bly 4 Unknown
of Vital Records, P.O	completed by P						24a. Wes an perform	autopsy ed?	evaile	autopsy findings able prior to pletion of cause ath?
Re	ege 2						1□ Yes	s 2'52 No		Yes 2□ No
		25. Was cese referred to medicel				26. Place of De	ath (Check only one			
of Vita	this certail direction.	examiner? 1 Yes 2 XNo	Hospital:	ient 2 ER/Out	patient 3 DOA	Other: 4 Nursing H	iome 5 Resider	nce 6 Othe	r (Specify)	mirisalai
o uois	within 24 hours after death. To the Funeral Director: After the completaly filled in by the funeral Medical Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investiga	1	ay Year) 28b. T		njury at Work? 1 🗆 Yes 2 🗆 No	28d. Describe how	w injury occurre	ed	
Division	rs after death. al Director: After tied in by the funer. Certification:	3 Suicide 6 Could no 4 Homicide determin	200. Place of II	njury - At home, fai tc. (Specify)	m, street, fectory, off	ice	28f. Location (Str. City or Town,		er or Rurel F	łoute Number,
Division	within 24 hours after death. To the Funeral Director: After completely filled in by the fune. Medical Certification		Physician: To the best caminer: On the basis end menner s	of examination and						
, i	To the company of the	29b. Signature and title of certifier				ense number		d. Date signed		
		I had wan	J N	~>	D	47611	C	CT. 19	1,200	00
		30. Name and address of person w		death (Item 23a) (Type, Print)	1204 back	Frezor	CMD	2170	20
	State	31. Date filed (Month, Day, Xear)		trar's Signature	4	1 .				
	Registrar	001 2	U ZUUU	Dagaras	P A	Darks				

DHMH 16 Rsv 6/95

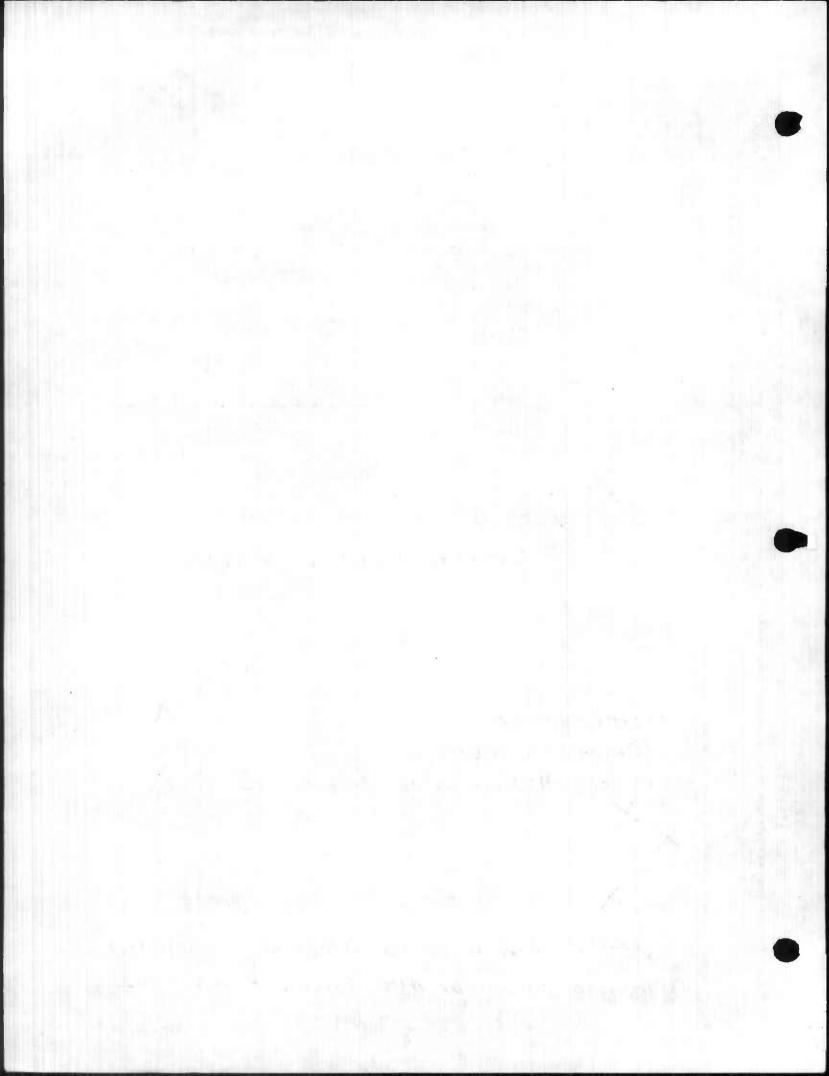


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Austin James Burdette October 13, 2000 8:30 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Frederick Frederick College View Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 1, 1915 9. Birthplace (State or Foreign Country)
Mary Land 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months MM 20F 217-10-9694 85 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits 28a-f show must be notified at Yes 2 No Frederick Frederick Directo Maryland 10e Street and Number 10f Zip Code 10g. Citizen of What Country? "natural", or flams 23a or United States 21702 812 Blakely Court Apartment 266 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) Hygiane. Plumbing Plumber permit. Pages 1 and 2 should be filled Department of Health and Mental Hygic important; if Item 27 is marked other 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be Bertha Elizabeth Sulcer Charles C. Burdette 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 812 Blakely Ct. Apt. 266 Frederick, MD 21702 Virginia Burdette / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2X Cremation 3 ☐ Removel from State 10/16/00 Frederick, Maryland Resthaven Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Skkot Cody, Licensed Mortician 21. Signature of Poneral Service Liqui 44 Tremaine Court Baltimore, MD 21244 23a. Part1, Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel Cerebrovaccular Strake disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Due to (or as a consequence ot): requires that the death certificate be execu Box 68760, Physician/Medicai Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 4 signed by t 3 Probably 4 Unknown Division of Vital Records, by 24b. Were autopsy tindings available prior to Completed 24a. Was an autopsy performed? peen iabetes mellitus completion of cause of death? hes page 2 devere 1 Yes 1 ☐ Yes 2 ☐ No ementia or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of D 28d. Describe how injury occurred 26a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier Medical To the Vithin 2 29b. Signatu d Jittle of certifie 29c. License number 29d. Date signed (Month, Day, Year) Hiren, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Au Thomas Thuson 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 16 2000

DHMH 16 Rav 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** Walter Baker 17, October 2000 11:01 P.M. /Medical 4e Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick H Under 1 Year H Under 24 Hrs. 8. Date of Birth Months Days Hours Min. A U.g. 16, 1942 9. Birthplace (Stata or Foraign 6. Sax 1 M 2 ☐ F 7. Aga (In yrs. lest birthday) **Funeral** 228-54-3728 58 Virginia Director Usual Rasidanca of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits "natural", or items 23s or 28s-f show 1 Yas 2 No Md. Frederick Brunswick Funeral Director the Medical Examiner must be notifi-10e. Street and Number 10g. Citizan of What Country? 10f. Zin Code 518 West Potomac Street 21716 USA 12. Was Decedant Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva 13. Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Rece - American indian, Black, Whita, atc. filed within 72 hours after 1 Navar Married 2 Married 1 Yas 2 No Saltimore, Maryland 21215-0020 Specify à 3 Widowed 4 Divorced White Yaar or Datas Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) Collega (1-4or 5+) Custodian School 17. Fathar's Nema (First, Middla, Last) 18. Mothar's Neme (First, Middle, Meiden Sumema) Department of Health and Mental Mingontant: If them 27 is mented oth any injury or other traumetic eventons. 88 B Otho Don Baker Minnie Estelle Carnes Pages 1 and 2 should nent of Health and Men 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) Shirley Baker - Wife 518 W. Potomac St. - Brunswick, MD 21716 20a. Mathod of Disposition
1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Steta 20b. Plece of Disposition (Nama of cematary, crematory or other placa) 20c. Location - City or Town, State Data Hagerstown Crematory 10/18/00 Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility John T. Williams Funeral 21. Signatura of Funeral Sarvice Licensee Home - Brunswick, MD 21716 23a. Part1. Entar the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximeta Intarvat Betwaen Onsat and Daath Physician Immediate Ceusa (Final disease or condition resulting In deeth) /Medical ABDOHINAL MOLTIC ANEURYSH WEEK Examiner Dua to (or as a consequence of) Examine The law requires that the death certificate be executed Sequantially list conditions, if eny, leeding to immadiata causa. Entar Underlying Cause (Diseasa or injury that initiated events rasulting in daath) Last Dua to (or as a consequence of): and attending physician for use as the bune Box 68760. Physician/Medicai Due to (or es e consequance of): Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco uss contributs to the cause of death? 1 ☐ Yss 2 ☐ No 3 ☐ Probably (Unknown by 24b. Were autopsy findings evailable prior to complation of causa of death? 24e. Wes an autopsy performed? Completed ata has b 2 No 1 Yas 2 No 1 Yas certificata or Attending Physician: 25. Wes casa rafarred to medical axaminar? Be 26. Placa of Daath (Chack only ona) Hospitat: 1 Mopatiant 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Yas 2 No 10 this 28a. Data of Injury (Month, Day Year) funeral 27. Menner of Deeth 28b. Time of injury 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? After t 1 Seletural 5 Pending invastigation ours after death. erel Director: Aff filled in by the fur 1 Yas 2 No 2 Accident 6 ☐ Could not be 3 Suicida 28f. Location (Straat and Number or Rurel Route Number, City or Town, Stata) 28a. Place of Injury - At home, ferm, street, factory, office building, alc. (Specify) datarmined 4 Homicida within 24 hours a
To the Funeral C To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Cartifiar (Check only one) 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura end titla of cartifiar D10587 UPMA 30. Nama and address of person who completed causa of death (Itam 23a) (Type, Print) FRE DERICH H&roline MEDICAL AFFAIR SHITH VICE PRE FREDERICK 31. Data filed (Month, Day, Year)

DHMH 16 Rsv 6/95

State

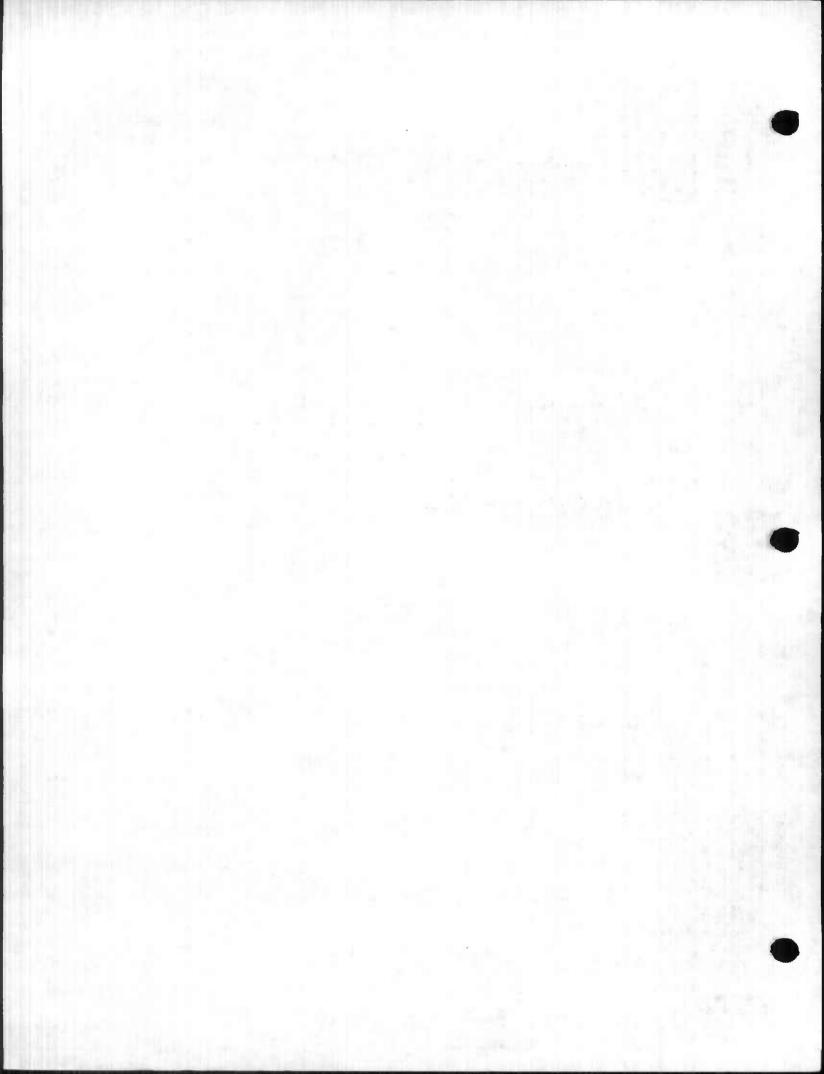
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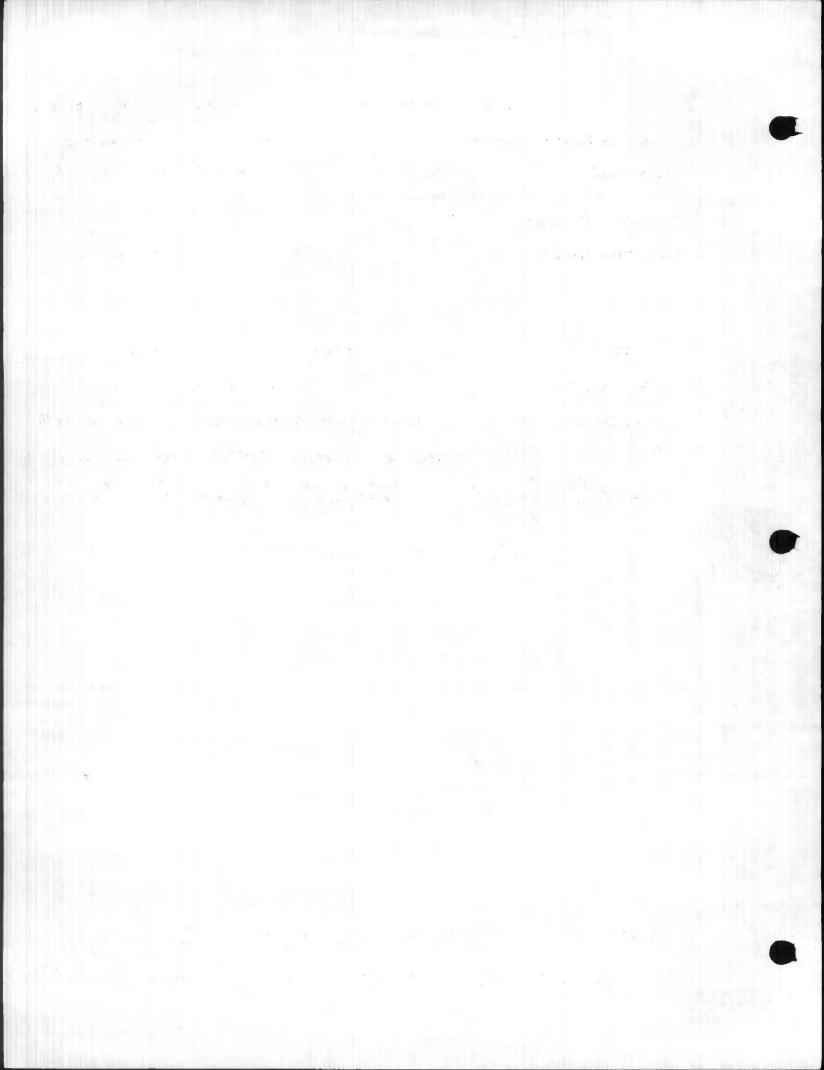
32. Registrar's Signatura



State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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							Timoato c	,, ,,	Datiri		Heg. No.		
	sician edical	1. Decedent's Name	(First, Middle		elen B	Belle Ben	nett			2. Date of Dominate Octobe	Day	Year 000	3. Time of Death 4:45am
0.7	niner	4a Facility Name (If	not institution	, give street and n	num <i>ber)</i>			4b.	City, Town, or L	ocation of Dear	h 4c. County	of Death	
Ø1		Montgomer	y Gene	ral Hosp	oital				Olney		M	lontg	omery
Fune	al	5. Social Security No		6. Sex	7. Age (/	In yrs. last birthday	If Under 1 Ye		Under 24 Hrs.	8. Dete of Bi (Month, D			plece (State or Foreign
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	-1	Usual Residence of				, 0				Dury L.	,		Lyzana
arylenc		10a. State	10b. County		10	0c. City, Town or L	ocation						10d. Inside City Limits
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eth w	Funeral	18718 Pik	ceview		ecedent Eve	- i- 11 0 1 40		208		'4. W A1	United		Ces can Indian.
ter dee	un un	11. Marital Status		Armed	Forces?	er in U,S. 13	Was Decedent If Yes, specify (or Hisp Cuban,	enic Origin? (Sp Mexican, Puerto	Pican, etc.)	Bia	ck, White,	
20 5		1 Never Marrie		If Yes, C	s 2⊠No Give		1□Yes 2☑	No :	Specify:		Specif	y: TT	1
15-0020 72 hours of "natural", or	d by	3 🖾 Widowed	4 Li Divorced	Year or	Dates:								hite
5-(5-)	Completed	(Speci	15. Decedent	's Education It grade completes	d)	16e. Dec	edent's Usuai Oceanical States	cupatione dur	on ing most of work	king	16b. Kind of B	iusiness/Ir	idustry
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ld by	10 B	Frank W.	Shinle	v				1	Helen M.	Hilto	n		
lary end M is mer	-	19a. Informent's Ne		-		19b. Mai	ing Address (St	_			per, City or Town	State, Zi	p Code)
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Pa Pa ment: ant:		4 Donation	5 ☐ Other (Sp	pecify)		Clarksbu	irg Ceme	ter	y 11/3	/2000	Clarks	burg,	Maryland
Baltimore, permit. Pages t ar Department of Heal Important: If item any Injury or other	ouce.	21. Signature of Eur	neral Service L	Licensee			2. Name and Ad			-		/	
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		23a. Part1. Enter the shock, or hear	t failure. List	only one cause or	eech line.	o douth. Do not of	nor and mode of	dynig.	30011 43 0410100	or roop notory			Interval Between Onsel and Death
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cords, P.O. By requires that the death been signed by the ette should be detached for	Completed by Physici	Part II. Othar algnifi-	cant condition	ns contributing to	death but n	not resulting in the	underlying cause	given	In Part I.	23b. Dld	tobacco usa co	entribute 1	to the cause of death?
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Sho sed of s	et									pen	oilled?	C	ompletion of cause
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Of V Physic this ce	2	1 ☐ Yes 2 ☐ d	60	Hospital: 1	Inpatient	2 ER/Outpatio	nt 3 DOA	Other:	4 Nursing H	ome 5 Res	Idence 6 DOt	her (Speci	ity)
9 Ph		27. Manner of Death		28e. Dat	te of Injury onth, Day Y	28b. Time	of 28c.	Injury a Work?	t	28d. Describe	how injury occur	rred	
olling in After a funer	tio	1 Naturai 2 Accident	5 Pending investig		Silli, Day 1	ear) Injury			s 2 No				
Division or Attending after deeth. Director: After din by the fune	Certification:	3 Sulcide	6 Could n	ot be 28e. Pla	ca of Injury	- At home, farm, s	treet, factory, off	ice	1	28f. Location	(Street and Num.	ber or Rui	ral Route Number,
or or or in b	T	4 Homicide	Geterrin	buil	Iding, etc. (Specify)				City or To	iwn, State)		
oltal urs urs illed	Ö	20- 0-46	-										
Division To the Hospital or Attending I within 24 hours after deeth. To the Funeral Director: After completely filled in by the funeral	edicai	Check only	☐ Certifying	g Physician: To the Examinar: On the	ne best of m basis of ex	ny knowledge, dea amination and/or l	in occurred at the rivestigation, in r	e time, ny opin	ion, death occur	end due to the red at the time	cause(s) and m date and pleca,	anner as	nated. to the cause(s)
the the plet	2	Ana)	1	and ma	anner stated	1.				12-2-11-2-2			
To To Too	Σ	29b. Signature and t	itle of certifier		1	21.1	29c. Lic	ense n	umber		29d. Date signe		
			///	Y	1	uns	1)	5(Y	457		OCTOBE	28 3	0,2000
		30. Name and addre	as othersho	who completed co	use of deet	h (Item 23a) (Type	Print)	/ 0			- 10170		0,2000 ND 20906
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Reg	strar		MON	A T COUN	100	- Allen	N 19	UPE	152			_	



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Yee **Physician** ace 10 27 2000 10:35 A.M /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner Nursing + Rehabilitation Cent hestertown If Under 24 Hrs. 8. Det Chestertown
5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Hours 1 M 2 X F Months Deys 222-07-3447 Director July 24, 1917 MARYland Usual Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limite "natural", or items 23a or 28a-f show adjust Examiner must be notified at 1 ☐ Yes 22 No Caroline Directo MARY AND Maryde 10f. Zip Code 10g. Citizen of What Country? Road 21649 by Funeral 7955 Zion Pages 1 and 2 should be liled within 72 hours efter death nent of Health end Mentel Hygiene. 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 7 is marked other than "natur traumatic event, the Medical 16b. Kind of Bustness/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Some One elses Home Home Maker 18. Mother's Name (First, Middle, Malden Sumame) 17. Father's Name (First, Middle, Last) Be 2 Kirk Wood Son Maggie Dickerson

19b. Mailing Address (Street and Number Daural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Hem 27 Cain Goldsboro, md. 21636 ete 20c. Location - City or Town, State 20b. Place of Disposition (Name of cametery, crematory or other place) HankFord Husband 20a. Method of Disposition important: If he any injury or conce. 1 Burial 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) /2000 Mary del, Mary land Mt. Zion enetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Bennie Smith Funeral 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiretory errest, shock, or heart feilure. List only one cause on each line. EASTON, Md. 21601 Approximate Interval Between Onset and Death **Physician** /Medical Artono Sclovetic Cardio Vascular Disease Immediate Cause (Final Meaks disease or condition resulting in deeth) Examiner Examiner physician and the burief-transit the deeth certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or as a consequenca of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) attending pl signed by the a Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee A No 3 Probably 4 Unknown Alzheimers Demontin Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? s certificate has b No No 1 Yes 1 TYes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 427 Nursing Home 5 Residenca 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 2 Accident 3 Sulcide 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours eft Funeral Di letely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) end menner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. 29a. Certifier Medicai To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signeture end title of cartifier 29d. Date signed (Month, Day, Year) 29c. License number D 50 996 inpleted cause of deeth (Item 23a) (Type, Print)

100 Brown Street,

hestertown, Md. 216

State Registrar a MD

32. Registrar's Signature

CASE CONTRACTOR OF THE PROPERTY.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Daath October 24, 2000 Crowell Helen Morrison 4e. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Somerset Princess Anne Marokin Manor If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthdey) 9. Birthplace (Stete or Foreign 1 □ M 20 F New Jersey Vrs 99 141-05-9928 Usual Rasidance of Dacedeni 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TYes 2 No Deal Island Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23124 Soundside Estates Drive 21821 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Bieck, White, etc. 1 Never Merrted 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced White 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Etamantary/Secondary (0-12) College (1-4or 5+) 12 Owner/Operator Gift Shop none 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumeme) Harry B. McKeag Anna Reid 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 21821 23124 Soundside Estates Drive, Deal Island, Md. Ruth Zollinhofer/Daughter 20b. Place of Disposition (Neme of commeter), cremetory or other place) Uniformed Services Univer. School of Medicine 10/25/00 Bethesda, MD 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriai 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hinman Funeral Home 21. Signeture of Funeral Service Licenses M00295 11673 Somerset Ave., Princess Anne, Md. 21853 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only ona causa on each lina. Approximate Interval Between Onset and Death Immediata Ceuse (Final diseasa or condition resulting In death) PNEUMONIA Dua to (or as a consequence of): LUNG NODULE Saquentially list conditions, if any, leading to immediate ceuse. Enter Undarlying Causa (Disaase or injury that initiated events resulting in death) Last Due to (or as a consequence ot): MELANOMA Due to (or as a consequence of) m

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Wed cal Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death of Department of Health end Mental Hygiens. Important: If flem 27 is marked other than "natural", or Items 234 any Injury or other traumatic event, the Medical Example man

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

Be

the Maryland

Completed by Physician/Medical

Examiner

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Certification: To

or Attending Physician: 24 hours after deat Funeral Director: within 24 hor To the Fune completely fi

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Part II. Other significant conditions of	entributing to death but not res	sulting in the underly	ring ceus	e given in	Part I.	23b. Did tobacco use co 1 ☐ Yes 2 ☐ No	ntribute to the ceuse of death 3 Probably 4 Unknow
						24a. Was an autopsy performed?	24b. Ware eutopsy findings available prior to completion of cause of daath?
						1□ Yes 2⊅No	1 ☐ Yes 2 ☐ No
25. Was case referred to medicel				26	Placa of De	ath (Check only ona)	
examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3[□ DOA	Other:	Nursing I	Home 5 ☐ Residence 8 ☐ Ott	ner (Specify)
27. Manner of Daath 1. Naturat 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Dey Year)	28b. Tima of Injury		Injury at Work? 1 ☐ Yes	2 🗆 No	28d. Dascribe how injury occur	red
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, atc. (Speci	ome, farm, streat, fa	actory, of	fice		28f. Location (Street and Number City or Town, Stete)	ber or Rural Routa Number,

29a. Cartifiai

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier

29c. License number DO 51359

29d. Date signed (Month, Day, Yeer) October 24, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12208 BRITHINGHAM LANE, PRINCESSANNE 21853 NATUSAN

State Registrar 31. Date flied (Month, Dey, Year) 30 32. Registrar's Signature

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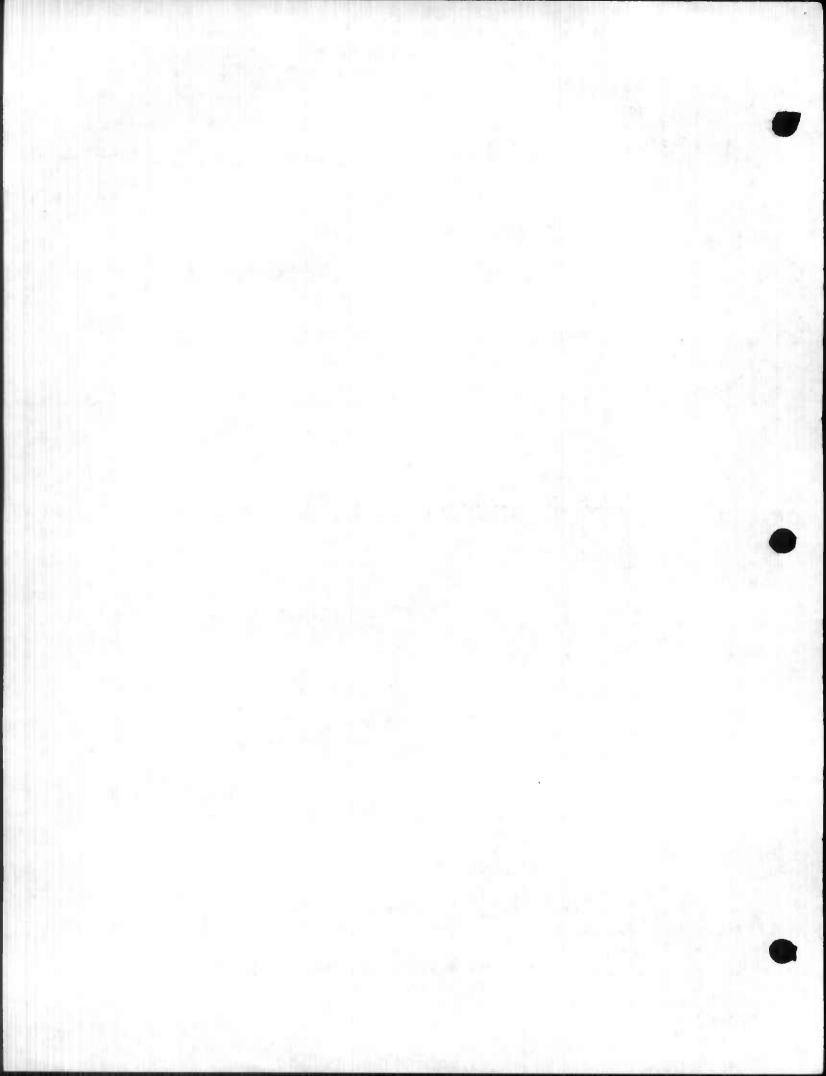
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named manager

State of Maryland / Department of Health and Mental Hygiene

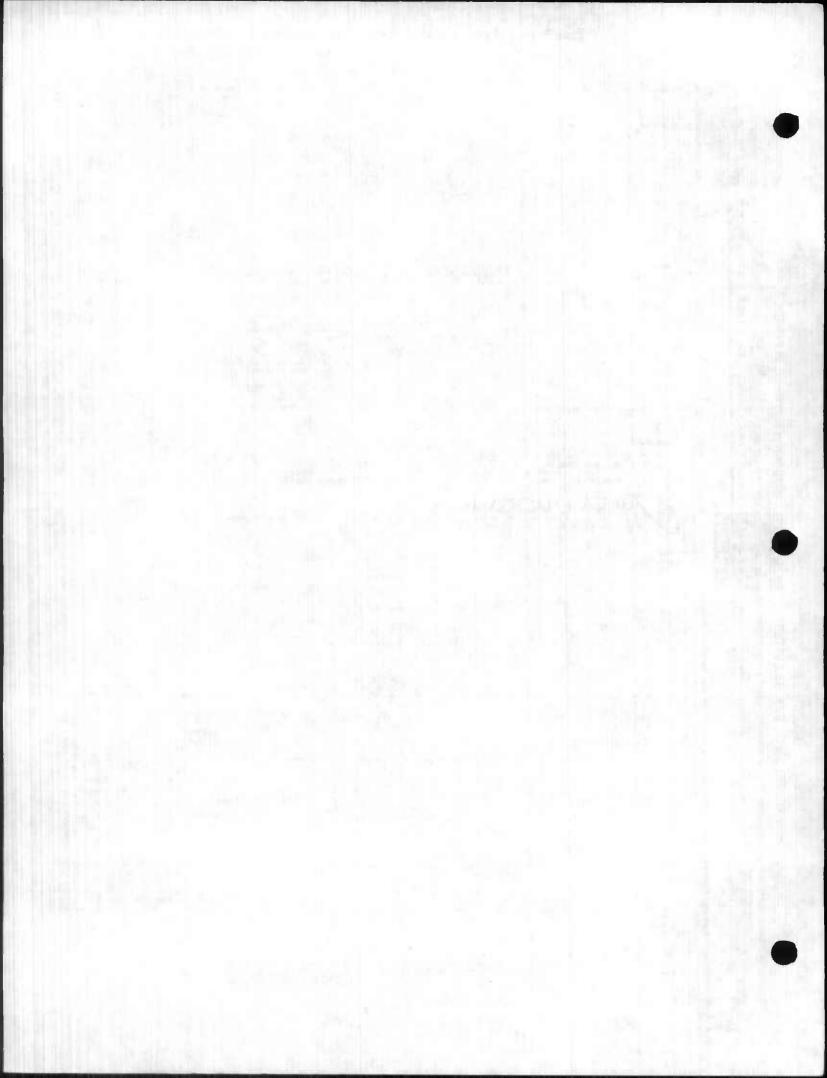
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hysician	Margaret	н.	Cox							000	9:2	5 PM
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ammer	Washington Adven	tist Hospit	a1			Tako	ma Pa	rk	Mon	tgom	ery	
al			In yrs. last birtho	day) If Under		If Under 2		Dete of Birth (Month, Day	1		lece (State	or Foreign
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Directo	Maryland Montg	omery		10f. Zip		na Par	K	1.	10g. Citizen of V	Whet Coun	trv?	
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by	1 ☐ Never Merried 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 ☐ Yes 2 🕅 No If Yes, Give Yeer or Detes:				Specify:			Specify		hite	
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00	12			Secre	tary						ernme	nt
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0	George E.	Hu	ghes, S	r.		A1t	а		Swit	zer		
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	21. Signature of Funeral Service Lice		oosar							-	, 111	
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r	diseese or condition resulting in deeth)	e. C620	5 DROK	10	m	may	hag	K			201	1347
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	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury											
edical	thet initieted events resulting in death) Last	C. De	e lo (or es a cor	nsequenca of):						1		100.00
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		d										
2	Pert II. Other significant conditions	contributing to death but	not resulting in t	he underlying c	ause gi	ven in Pert I.		23b. Did t	obacco use co	ntribute to	the cause	of death
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Ŧ	4 Homicide determine	building, etc.		1, 511001, 100101)	, 011100			City or Tox	vn, State)			
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~	29b. Signature end title of certifier	108	. 2	290	. Licens	se number	(1)		29d. Dete signe	a (Month)	Day, rear,	
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	8	Usual Rasidence of Decedant 10a, Stata 10b, County		10c. City, Te	oum or to	ontion							10d. Inside City Limits
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21215-0020				10	6a. Dece	dent's Usua	l Occup	pation	of words	ina	16b. Kind of Bu	siness/in	dustry
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alti	Partm Partm Pinju	4 Donation 5 Othar (Specify) Holy Name Cemetery 11 21. Signature of Fjunaral Service Licensee 22. Nama and Addrass of Facility Metr							ropoli	tan Fune	ral	Service	
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	Physician	23a Party Enley the disease, or co	mplications that caus ly <i>on</i> a causa on aach	ed the death. E	Do not en	ter tha moda	a of dyir	ng, such as	cardiac	or respiratory a	rrest,	# #	Approximate Intarval Between Onset and Death
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ה ה	rs after d al Direct led in by	3 Suicida 6 Could not	ZOU. PIECE OF	Injury - At home etc. <i>(Specify)</i>	, farm, st	reet, factory	, office			28f. Location (City or To		per or Rui	ral Routa Number,
	in 24 hours he Funer plately fill	29a. Certifier 1 Certifying (Check only one)	Physician: To the bes aminer: On tha basis and mannar	ot axamination	dge, deat and/or in	h occurred a vastigation,	at the tir in my c	me, date an opinion, dea	d place, th occur	and due to the red at the tima,	causa(s) and ma date and placa,	anner as	stated. to the cause(s)
		29b. Signatura and titla of cartifiar	Libr	ē n	G,	290		sa number 19470			29d. Data signe 10-31		, Day, Year)
		30. Nama and addrass of person with Eugene P. Libre		daath (Item 23 00 Conn	a)(Type, ecti	Print)	re K	ensin	gton	, MD 2	.0895		7 3 7 3
	State Registrar			strar's Signatura		doo	uls						

DHMH 16 Rev 6/95



Division of Vital Records,

219-26

サング

The law requires that the death certificate be Physician: or Attending within 24 hours a
To the Funeral C

signed by the a certificate has this funeral

by Be 0 Certification:

ours after death. eral Director: After th filled in by the funeral

edical

SHIKHAR 31. Data filed (Month, Day, Year)

NOV 14

Hypertension

5 Panding Invastigation

6 Could not be determined

25. Was case reterred to medical

29b. Signature and title of certifian

1 Yes 2 No

27. Manner of Death

2 Accident

3 ☐ Sulcide

29a. Certifier

4 ☐ Homicide

riklar 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

6,000

Chronic obstructive bulmonary Disease

28a. Date of Injury (Month, Day Year)

Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

AN HOSPTAL AMAR 32. Registrer's Signatura renerva

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of causa of death?

1 Yes 2DNo

24a. Was en autopsy performed?

1 Yes

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Plece of Deeth (Check only one)

2 No

281. Location (Street and Number or Rural Routa Number, City or Town, State)

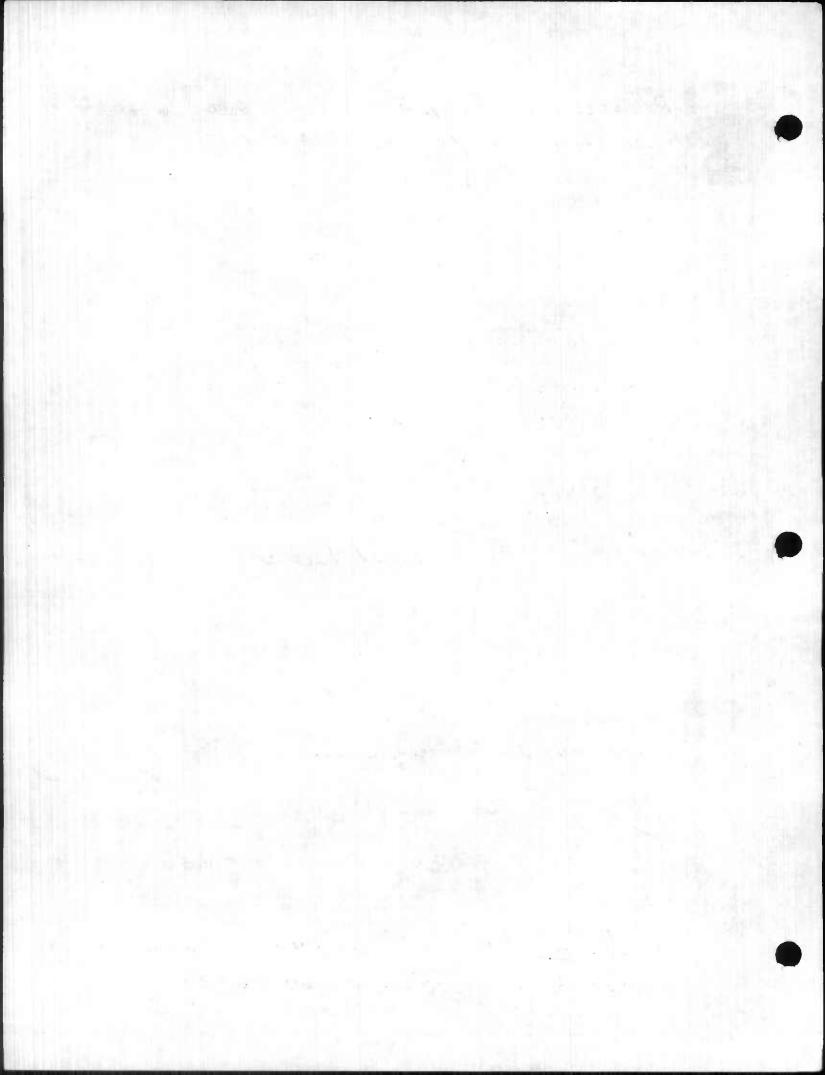
29d. Date signed (Month, Day, Year)

october, 30, 2000

ORIGINAL

State Registrar

DHMH 16 Ray 6/95



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 3. Time of Death 2. Deta of Death Month **Physician** Elizabeth S. Connell October 25, 2000 8:55 PM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fairland Nursing Home Silver Spring Montgomery If Under 1 Year If Undar 24 Hrs. 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 F Months 050-05-4857 89 Director Dec 29, 1910 New York Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23s or 23s-1 show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Montgomery Silver Spring å 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1716 Overlook Dr 20903 Funeral USA 14. Race - American Indian, Wes Decedent of Hispanic Origin? (Specify Yas or No-It Yas, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Status 12. Was Decedent Evar In U,S. Armed Forces?

1 Yas 2 No If Yes, Give Yaer or Detes: Bleck, White, etc. 72 hours after 1 Never Married 2 Married 1 Yes 2√ No Specify: Specify: White by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Mad within Elementery/Secondery (0-12) Collega (1-4or 5+) Hygiana. q Naval Hospital Secretary permit. Pages 1 and 2 should be fin Department of Health and Mental Hy Important: If Nem 27 is marked other any injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) 96 Thomas Stelle Beulah Barker 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) Gwendolyn Mollison/Friend 1716 Overlook Dr, Silver Spring, MD 20903 Baltimore, 20e. Mathod of Disposition 20b. Piece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Everly Crematory Oct 29 Fairfax, VA 21. Signeture of Funerel Service Licensee 22. Nema end Address of Fecility Hines-Rinaldi Funeral Home nel () alan 0 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Pert1. Enter the disaesa, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory arrest, shock, or heert failure. List only one cause on ago to the control of the **Physician** Immedieta Cause (Finel disaase or condition resulting in deeth) /Medical Examiner Dua to (or as e consequance ot) Examin physician and the burial-transit that the death certificate be executed Sequentially list conditions, if any, teading to immediata cause. Enter Underlying Cause (Disease or Injury that in the land of the land o Due to (or es a consequence ot): Box 68760. Physician/Medical thet initieted events resulting in death) Last Dua to (or es a consequence of): 98 USB ed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the undarlying ceuse given in Pert I. o 2 No 3 Probably 4 Unknown signed by 1 Yee O. Records, þ requires 8 24b. Were eutopsy tindings available prior to complation of cause of death? 24a. Was en autopsy performed? Completed peen The law page 2 certificate has 1 Yes Division of Vital Physician: funeral director, Be 25. Wes cese reterred to medical 26. Placa of Death (Check only one) 1 Yes 2 Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death

1 Netural

2 Cident 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury at Work? 5 Pending investigation or Attanding a Funeral Director: At Setely, Albetely filled in by the fu death. 1 ☐ Yes 2 ☐ No 6 Could not be datarmined 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ SuicIde 28e. Plece of Injury - At home, farm, street, fectory, office building, atc. (Specify) 4 ☐ HomicIde Hospital 1 Certifying Physician: To the best of my knowledge, daeth occurred at the time, data and place, and due to the causa(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. edical 29e. Certifier completely (Check only within 2 one) To the 29c. License number 29b. Signeture and title-29d. Date signed (Month, Dey, Year)

State Registrar 31. Deta filed (Month, Dey, Year)

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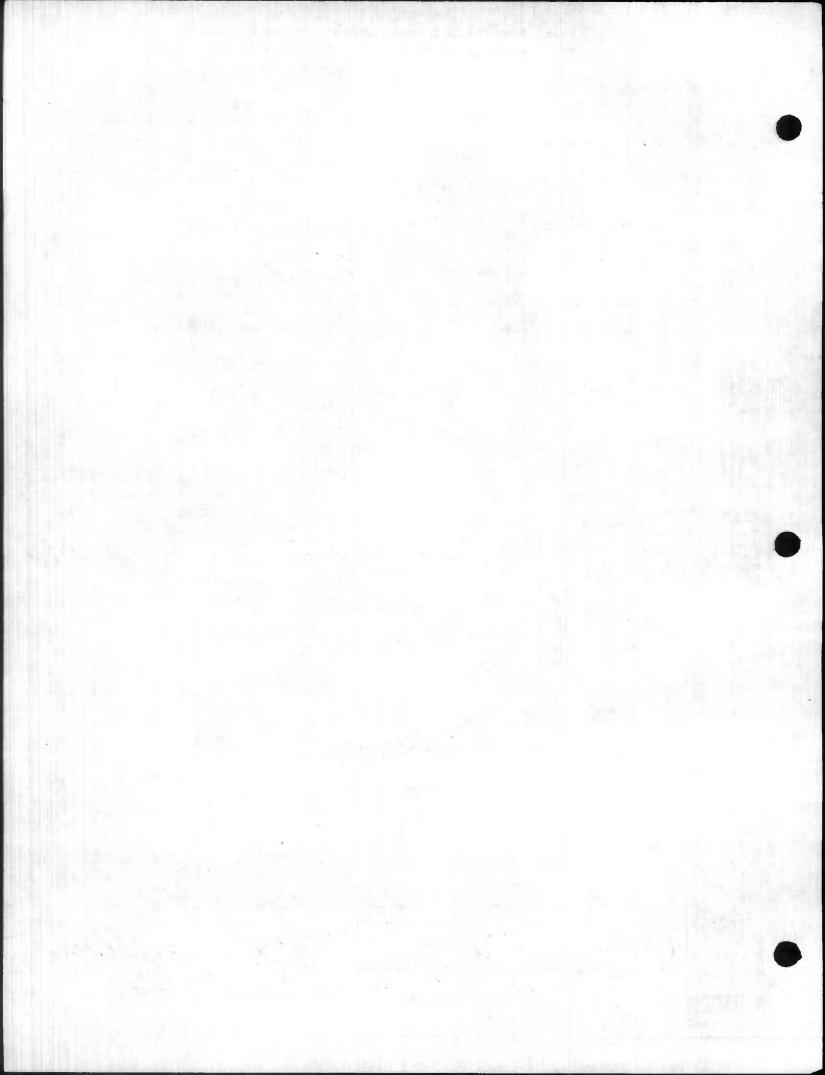
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a

30. Name and address of person who completed ceusa of death (Item 23a) (Type, Ppint) COLUMN

Kane

32. Registrar's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death

					Cert	tificate c	n Dean	,	1 -	Reg. No.	0 00105	
hysician /Medical	ELSI	s Name <i>(First, Middle</i> EESCHNECK	CLEMENT						2. Dete of D Month OCT	29	3. Time of Deal 2000 3:23 P.	
xaminer	4e Fecility N	eme (If not institution	n, give street end r	num <i>ber)</i>			4b. City, To	own, or L	ocation of Dear	th 4c. County	of Death	
		ONAL NAVA			to a de l'ade de la	If Under 1 Ye		HESDA r 24 Hrs.	A	MONTO	GOMERY	
neral ector	5. Social Sec 184-12		6. Sex 1 □ M 2 ☑ F	7. Age (In yrs. 78		Months De		Min.	8. Dete of Bi (Month, D March	21, 1922	9. Birthplace (State or For Country) Pennsylvani	eign a
	Usual Reside	ance of Decedent		1400 010	. Tour out on	ntina					404 1-14-01-11	- 14 -
T T	MD			Tod. City	y, Town or Loca						10d. inside City Lir	
nouthed notthed			gomery		Bethes	_	•			40. 00		-
	7913		erlook Di			10f. Zip Cod				10g. Citizen of \		
iner marte notified	11. Marital St			ecedent Ever in U.	S 13 W		0817	rigin? (Sp	ecify Yes or N		A . se - American Indian,	
L'A	1.00	ratus or Married 2□ Merr	Armed	Forces?	.s. 13. W	Yes, specify C	Cuben, Mexica	n, Puerto	Rican, etc.)		ck, White, etc.	
>		wed 4 Divorced	If Yes (Give	11	☐ Yes 2월!	No Specify	r:		Specify	White	
		15. Decedent	t's Education		16a. Decede	ent's Usuai Oc	cupation			16b. Kind of B	usiness/Industry	
ple ple	Elementen	(Specify only highes y/Secondary (0-12)	st grede complete	d) (1-4or 5+)	(Give k	ind of work do O NOT use re	one during mo: tired)	st of work	ring			
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	John	J. Schne	ck				A	nna :	Lander			
traumetic sve To Be	19a. informe	nt's Neme/Relations	hlp (Type, Print)		19b. Mailing	g Address (Str	raet and Numb	ber or Rur	el Route Numi	ber, City or Town,	Stete, Zip Code)	
3 -	Charle	s E. Clem	ents	Step-son	4719	48th S	t. N.W	. W	ashingt	ton, D. (C. 20016	
or other		of Disposition	3 □Removal from	m State	Place of Disposi emetery, creme	etory or other	plece)		Date		City or Town, State	
ury or o		ation 5 Other (Sp		Arl	ington						on, Virginia	
any injury	21. Signature	e of Funeral Sarvice	Licensee	L. L.					-	wler's S ngton, D		
	snock,	or haart failura. List	only ona causa or	t caused the death a ach line.	h. Do not enter	r the mode of	dying, such as	s cardiac	or raspiratory	arrest,	Approximata Interval Between Onset and Death	
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State Registrar

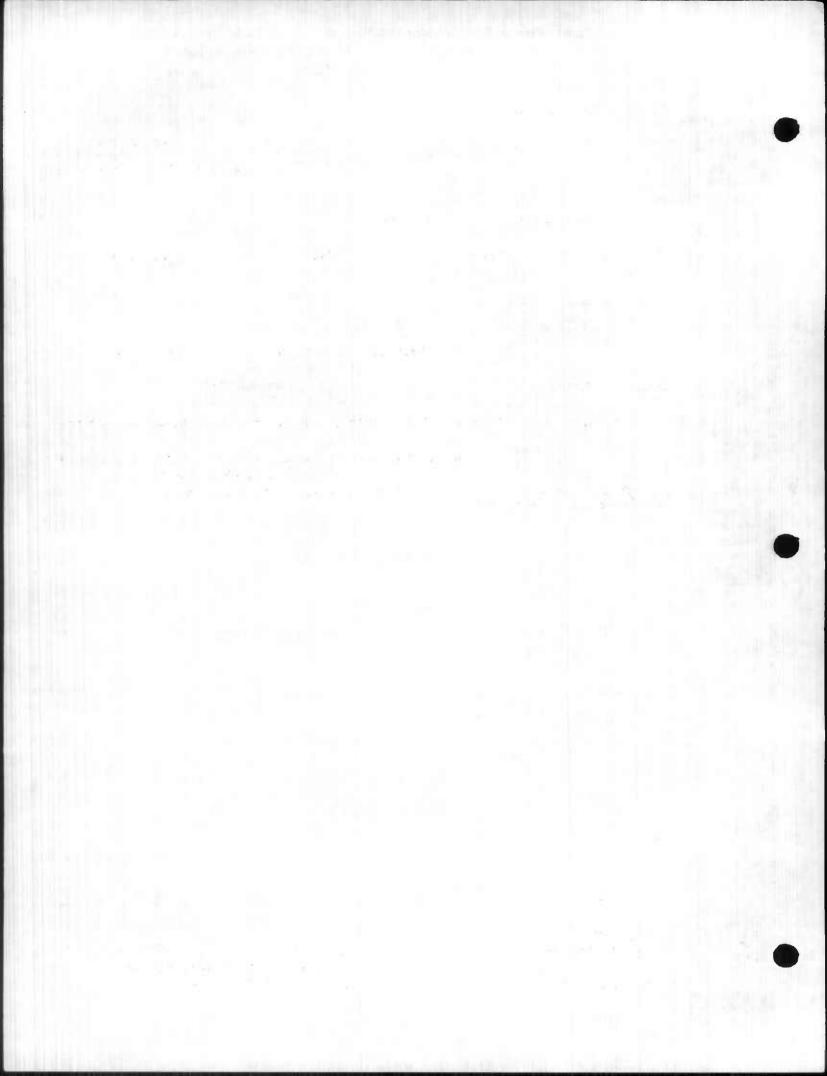
LUTHER CARTER LT, MC, USNR

31. Date filed (Month, Dey, Year)

NOV 6 2 2000

32. Registrar's Signature

Spally BETHESDA, MD 20889-5600



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** ANNELIESE H. CLANCEY OCTOBER 29 01:25 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) **Examiner** MONTGOMERY GENERAL HOSPITAL MONTGOMERY OLNEY | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 18 1930 Birthplace (State or Foreign Country)
 Germany 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 20 F Yrs. 212-62-2437 70 Director Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours efter death with the Manyland neal of Heelth and Mentel Hyglene.
Int: If item 27 is marked other than "natural", or items 23s or 28s-f show any or other transmit be notified all any or other transmit be notified at any or other transmit be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland Carroll Sykesville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 256 West Old Liberty Road 21784 United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White þ 3 M Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 0 12 Waitress Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wilhelm Haussner Margaret Unknown 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 256 West Old Liberty Rd., Sykesville, Md. 21784 Michelle Clancey-Cole/Daughter 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Date Department of Important: If it any Injury or o 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory 10/30/00 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Muriel H. Barber Funeral Home 21. Signature of Funeral Service License P.O. Box 5038, Laytonsville, Maryland 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Vist only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) 4 DAYS PN EVMONIA Examiner Due to (or as a consequence of): Examiner ettending physician end for use es the burial-transit law requires that the death certificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequenca of): P.O. Box 68760, Physician/Medical Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 ≥ Yes 2 No 3 Probably 4 Unknown PHEASE, SEVERE CHRONIC OBSTRUCTIVE PALMONARY Division of Vital Records, p 24b. Were autopsy findings available prior to bluods 24a. Was an autopsy performed? Completed completion of cause of death? s certificete hes l 1 ☐ Yes 2 ☑ No 1 Yes 2 No Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this funerel 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending Investigation 1 Natural death. 1 ☐ Yes 2 ☐ No Director: A 2 Accident 3 Sulcide 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide ò To the Hospital o within 24 hours aff To the Funerel Di completely filled in edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) R friedon 10 30 00 D34740 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DLNEY 20832 POBERT P FIELDS MO 18111 PRINCE CHILIP OR T-12 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

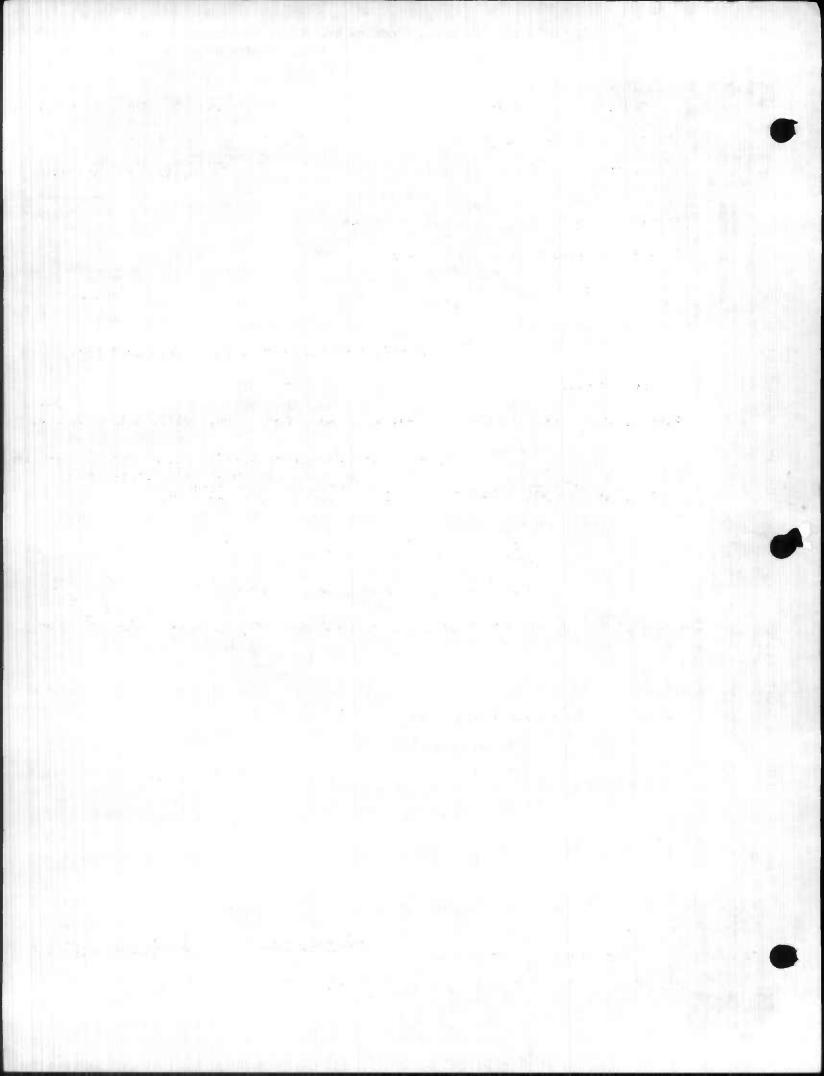
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	r (Specify)	om state						
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						10	Yes 2 No	1 Yes 2 No
Wes case referred to med exeminer?			/			eeth (Check only	one)	
1 Yes	Hospitel:	1 ☐ Inpatient ≥	ER/Outpetler	nt 3 DOA	Other: 4 Nursing	Home 5 ☐ Resi	dence 6 Other (Sp	ecify)
Menne of Deeth	28e. D	ele of Injury Month, Dey Year)	28b. Time of Injury	28c. lr	njury et Work?	28d. Describe	how injury occurred	
/	estigation				1 ☐ Yes 2 ☐ No			
1 ☑Naturel 5 ☐ Pe 2 ☐ Accident inv	uld not be termined 28e. F	lece of Injury - At I uilding, etc. (Spec	nome, farm, str ify)	reet, fectory, offi	ice	28f. Location (City or To	Street end Number or I wn, Stete)	łural Route Number,
1 ☑Naturel 5 ☐ Pe 2 ☐ Accident inv 3 ☐ Suicide 6 ☐ Co	b	the best of my kn						
1 Naturel 2 Accident 3 Suicide 4 Homicide 6 Co	ifying Physician: To	ne basis of examin		29c. Lic			29d Dete signed (Mor	nth, Day, Year)
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1 2 3	I ∐ Homicide	Cartifying Physician: To		2 Medical Examiner: On the basis of examinetion end/or in end menner steted.	2 Medical Examiner: On the basis of examinetion end/or investigation, in n end menner steted. Sphalure and title of certifier 29c. Lice	2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occent end menner stated. Signature and title of condition 29c. License number	2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, and menner stated. 29c. License number 25c. 25c. 25c. 25c. 25c. 25c. 25c. 25c.	2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due and menner stated. Spinature and title of certains: 29c. License number 29d. Date signed (Mor



State of Maryland / Department of Health and Mental Hygiene U	361	40
Certificate of Death		

	Decedent'a Name (First, Middle, Last)								2. Date of De			. Time of Death	
Physician /Medical	ELIZABETH MARY CHOATE 4e Facility Name (If not institution, give street and number) MANOR CARE OF CHEVY CHASE								NOVEMB			2:30 PM	
Examiner							46. City, Tov		cation of Deet SE		4c. County of Deeth MONTGOMERY		
uneral	5. Social Security Number	6. Sex 7.	Age (In yrs. I	last birthday)	If Under Months		If Under a	24 Hrs.	8. Date of Bir (Month, De	rth	9. Birthplace	(State or Foreign	
rector	141-38-2900 Usuel Residence of Decedent	10 M 20 F	90	Yrs.	Months	Days	riouis	Will.	Aug 4,	1910	Pennsy	lvania	
el', or items 23a or 28a-f show Examiner must be notified at by Funeral Director	10a. State 10b. County	10c. City	10c. City, Town or Location							10d.	inside City Limits		
	Maryland Montgomery			Kensington								1 ☐ Yas 2 No	
	10e. Street and Number			10f. Zip				10g. Citizen of What Country					
	3618 Littledale				2089				United S				
	11. Marital Status 1 Navar Merried 2 Marri 3 Widowed 4 Divorced	nt Evar In U, us? ∑ No s:		dent of H city Cub 2 No	of Hispanic Origin? (Specify Yas o Cuben, Mexican, Puerto Rican, etc. No Specify:			Specify	inden,				
	15. Decedent		16a. Deced	lent's Uau	el Occup	petion	.445	16b. Kind of Business/Industry					
ple ple	(Specify only highas Elementery/Secondery (0-12)		College (1-4or 5+)		16a. Decedent's Uauel Occup (Giva kind of work done life. DO NOT usa retire			ad) auring most or working		L PI			
Completed		2		Housewife						Own Ho			
89	17. Fathar's Nama (First, Middla, I			18. Mother's						, Maiden Sumen			
raumetic e To B	Percy Caro	0	c	Edna					Adel Reisse				
	19e. Intorment's Name/Relationsh									er, City or Town,			
Nam 27 is m other traum	Thomas William	Choate, So					th Dri	-		Chase,		0815	
õ	20e. Method of Disposition 20b. Place of Disposition (Nama of cemetery, crametory or other place) 20c. Location · City or Town, Steta 20c. Location · City or Town, Steta												
my injury	21. Signature of Funeral Service Liberture 22. Name and Address of Facility DeVol Funeral Home												
88	1 January	n the		10	E. I)eer	Park	Dr.,	Gaith	ersburg	, MD 2	20877	
cian	23a. Pert1. Enter the dise of shocks or heart tellur. Lat	complications thet caus only one cause on each	sed the deeth	n. Do not ente	er the mod	de of dyir	ng, such es	cardiac o	r respiretory (arrest,	Int	proximate ervel Between nset and Death	
ical	Immediete Ceuse (Final diseese or condition	5								1 DAY			
er	disease or condition resulting in death) SEPSIS Due to (or es a consequenca ot):									_			
Examiner		GANGRI	GANGRENE								1 MONTH		
ledicai Examir	Sequentially list conditions,	0.	Due to (or es a consequence of):										
Ē	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Causa (Disease or Injury	HERAL	VASCUL	AR DI		YEARS							
edicail	that initiated events resulting in death) Last Due to (or as a consequence of):												
Physician/N	Dart II. Other electificant and the		hua met ee	Min = to Ab -	- d - d - d -		ma la Bassi	-	nes Di	I tohono was	untulbure en et	a series of death	
Nys!	ren II. Other significant condition	1 out not resu	sulting In the underlying cause given In Part i.					23b. Did tobacco use contribute t					
4	HYPOTHYR	OID	1							188 ZU NO	VII F10080	-y -W outling	
cate has been signed by the attendin . page 2 should be detached for use Completed by Physician/A	24e. Wes operfor							s en eutopsy ormed?	24b. Were autopsy ti evaliable prior to completion of death?				
								10					
BeC	25. Wes case reterred to medical 26. Piace of De							of Death	1 Yes 2 No 1 Yes 2 No				
his certificate if director, par To Be Co	examiner? 1 ☐ Yes 2 ☑ No	Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Mill Nursing Home 5 Residence 6									Other (Specify)		
T: T	27. Manner of Death	28a. Dete of I	28b. Tima of 28c. Inj					28d. Describe how injury occurre					
atio atio	1 Neturel 5 Pending 2 Accident invastig		Day Fodf)	Injury M			1 ☐ Yes 2 ☐ No						
Certification:	3 Suicida 6 Could n determi	ZOO. PIECE OI	28e. Pleca of Injury - At home, term, street, factory, offica building, etc. (Specify)							28t. Location (Street and Number or Rural Route Number, City or Town, Stete)			
mpletely filled in by the funeral director, page Medical Certification: To Be Com	(Check only 2 Medical E	Physician: To the becaminer: On the basis	of exeminet	wledge, death	occurred vestigation	et the ti	me, date en	d pleca, a	and due to the	cause(a) and m	annar as state	ed. e cause(s)	
@ Q	one)	end menner	steted.			6	sa number			29d. Dete signe			

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NOVEMBER 2, 2000 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)
ELLEN PINHOLT, M.D., 5530 WISCONSIN AVENUE, #1045 CHEVY CHASE, MD

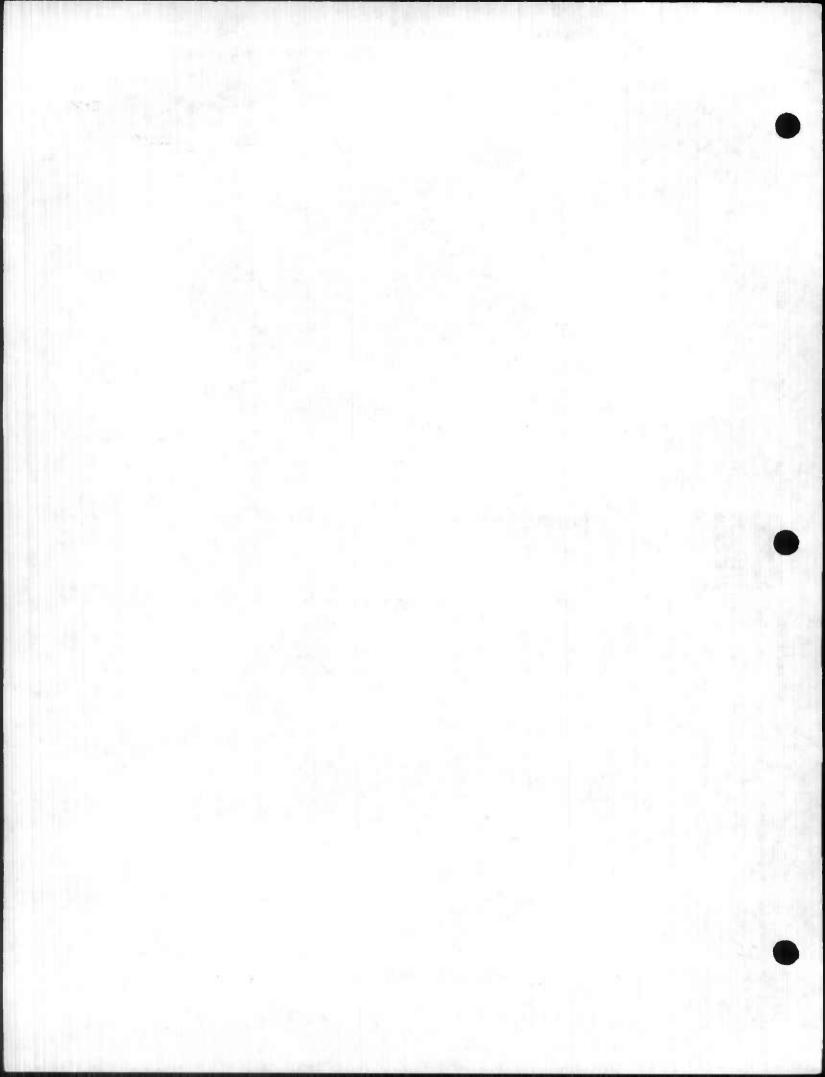
State Registrar

31. Dete filed (Month, Dey, Year)

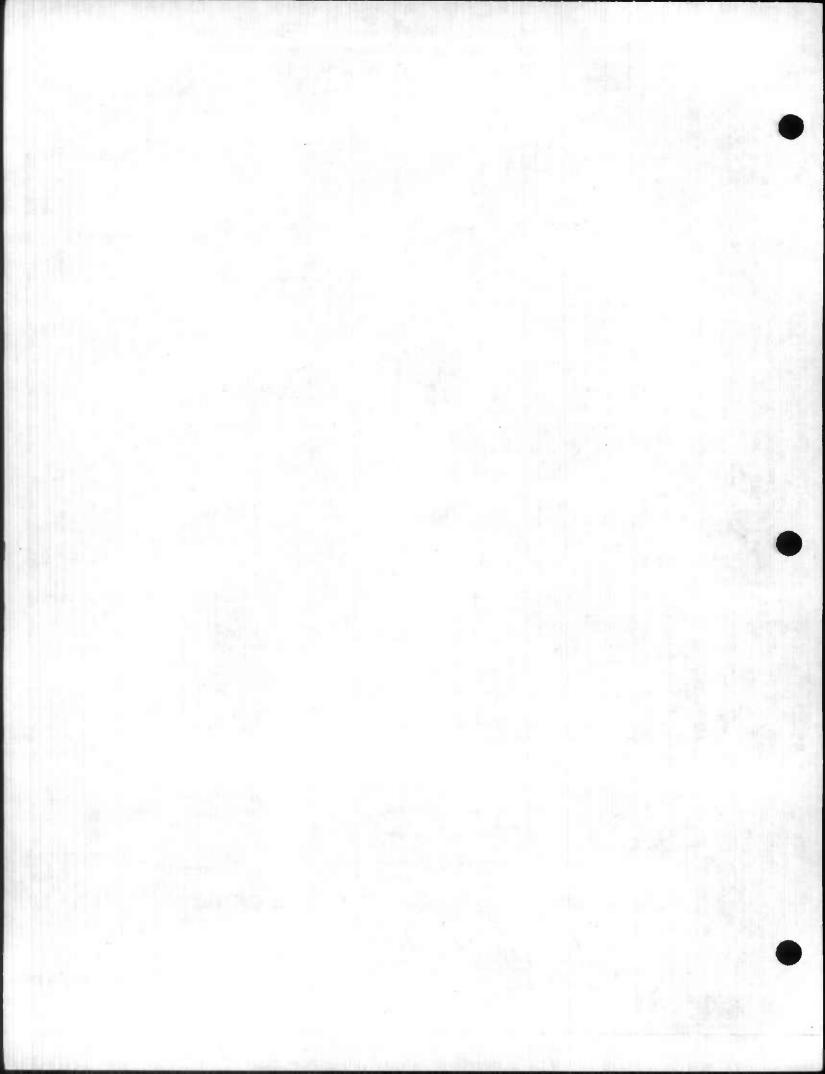
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32. Begistrar's Signatura

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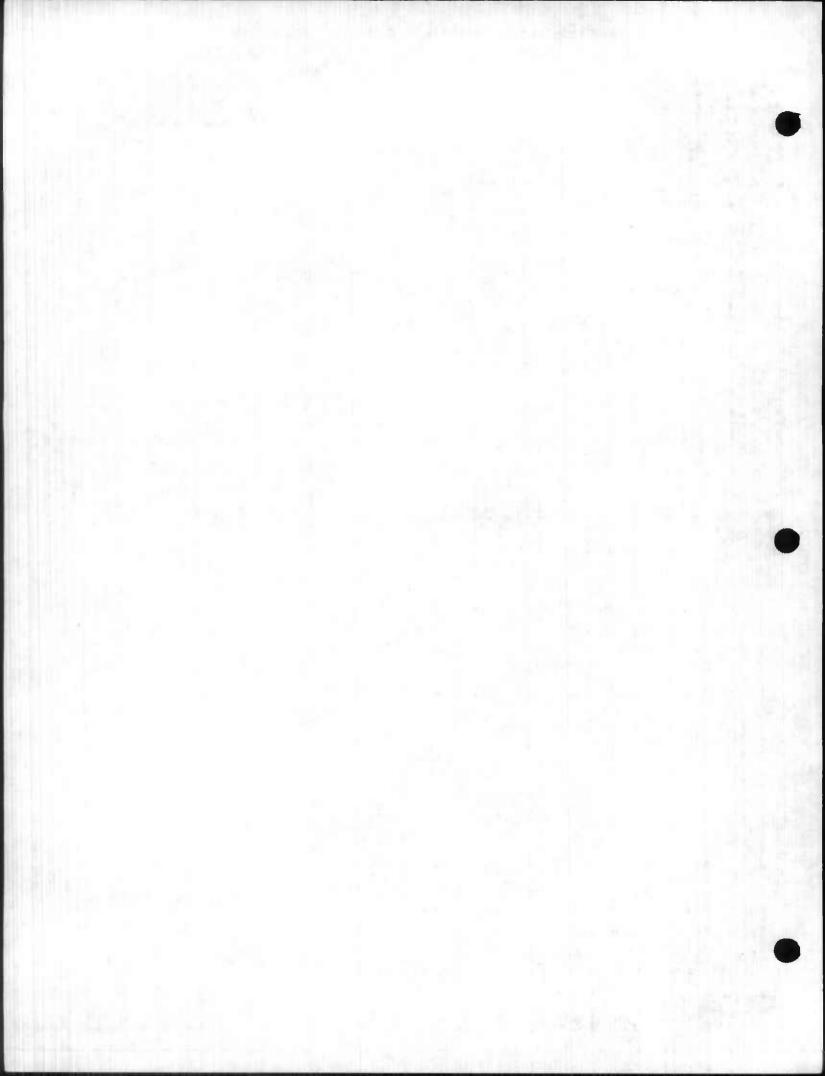
State of Maryland / Department of Health and Mental Hygiene | Certificate of Death Rea. No. 3. Tima of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Margaret Sniffin Chirieleison 5:10 pm October 30, 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3019 Ferndale Street Kensington Montgomery 8. Date of Birth (Month, Day, Year) Jan 22, 19 If Linder 1 Year If Undar 24 Hrs. 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Days 10 M 20 F Months Hours 83 Yrs. 1917 Director 577-03-8006 Usual Rasidence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits or items 23s or 28s-f show sminer must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Kensington 2 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 3019 Ferndale Street 20895 USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 24☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, 11. Marital Status the Medical Examiner. Black, White, etc. hours after 1 Never Married 2 Married 1 Yes 2 No Specify: Maryland 21215-0036 Specify: White þ 3 Widowed 4 □ Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) 72 filled within than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12 Secretary Clerical 18 Mother's Name (First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fill.
Department of Health and Mental Hy
Important: If them 27 is manked oth any Injury or other traumatic even Millard M. Sniffin Mildred Behncke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zio Code) Don M. Chirieleison / Son 409 Victoria Court, Vienna, VA 22180 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State Metropolitan Crematory 10/31/00 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 21. Signature of Funeral Service Licensee len Like 500 University Blvd., W, Silver Spring, MD 20901 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** anon Immediate Cause (Final disease or condition resulting in death) /Medical 10 Examiner Due to (or as a consequenca of): Examine death certificate be executed physician and the burial-transit Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medicai Due to (or as a consequence of): 98 950 P.O. ed by the detached Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? that the signed by t d be detach 1 Yaa 2 No 3 Probably Wunknown Records. by law requires 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peen page 2 certificate hes The 1 Yes No Division of Vital Physician: 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 After this funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: Natural 2 Accident or Attending 5 Pending death. 1 TYes 2 No investigation 24 hours efter deat 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital cai 29a. Certifier niner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and dua to the cause(s) and manner stated. (Check only one) To the F 29c. Licansa number 29b. Signatura and title of cert 29d. Date signed (Month, Day, Year) 30. Name and address of person completed cause of death (Item 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 01 ZUUU



State of Maryland / Department of Health and Mental Hygiene 00 36144

				Cei	rtificate	e of	Death			Reg. No.		00177	
	1. Decedent's Neme (First, Middle, Last)								2. Date of De	eath		3. Time of Deeth	
Physician	Margeret H. Chewning								Month Novembe	er 2, 20	Year	9:25 am	
/Medical							4b City To		cation of Deel		y of Death	3.23 all	
Examiner	4a Facility Name (If not institution, give street and number) Rockville Nursing Home												
			1		If I loder		Rockv		0.0	Montg			
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs			Months Deys Hours Min.			Min.	8. Date of Bi (Month, D	ay, Year) Country)		placa (State or Foreigntry)		
Director	577-28-2000		80	115.					Jan 14	, 1920	Penn	ennsylvania	
2 .	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d,										IOd Incide City Limit		
the Maryland 28a-f show notified at ector											1 ☐ Yes		
oto die o	Maryland Montgomery Silver Spring								1 LI Ye				
or 28s-f. be notified	10e. Street and Number		10f. Zip Code					10g. Citizen of What Country?					
at a si	3362 Gleneagles		20906					USA					
in 72 hours after death with the Marylai "natural", or larne 23s or 28s-1 show selical Examiner must be notified at letted by Funeral Director	11. Meritel Stetus 12. Was Decedent Ever in U,S. Armed Forces?				13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuben, Mexican, Puerto					o- 14. Ra	ce · Americ		
within 72 hours after noe. than "natural", or its he Medical Examine ompleted by Fur		No No	77					Hican, etc.)	Ble	eck, White,	etc.		
, A	3 Widowed 4 □ Divorced If Yes, Give 1 □ Yes						Specify.		Speci	y Whi	te		
De par		15. Decedent's Education 16e. Decedent's Usual Occupation								16b. Kind of E	Business/In	dustry	
ygione. yellone. tt. the Medical.	(Specify only highest grade completed)			(Give kind of work done during most of wor life. DO NOT use retired)					ing				
than the Mo	Elementery/Secondery (0-12)	College (1-4	College (1-4or 5+)		Sales Associate					Retail	Potoil		
Co at a	17. Father's Neme (First, Middle, La	o#1	bales			18. Mother's Nem							
D SOE			18. Mother's Nen										
marked other marked other unaffic event, I	Alfred H. Haag									Hoover			
- 0 重量	19e. Informant's Neme/Reletionship		1	9b. Mailir	ng Address	(Street	end Numb	er or Aur	al Route Numb	Code)			
f Health Item 27 Other tr	Karen E. Scott/	Daughter					ird T	erra	ce, Gai	thersbu			
を見る	20e. Method of Disposition	20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place)						1	Dete 20c. Location - City or Town			own, State	
2 = 0	4 Donetion 5 Other (Spec		910		tan C			1	1/3/00	Alexand	ria.	VA	
Separtmen Separtmen mportant: my injury anse.	21. Signature of Funeral Servica Lic	**		-							,		
SEES	Francis J. Collins Funeral Home, Inc. 20901												
ALCON MARKET	500 University Boulevard, W., Silver Spring, MD												
	23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, of heart failure. List only one ceuse on each line.												
hysician	Onset and Death												
/Medical	Immediate Cause (Final disease or condition Hypertensive Heart Disease												
Examiner	resulting in deeth)												
6	Due to (or es e consequence of):												
mir	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Atrial Fibrillation Due to (or as a consequenca of): Chronic Lymphocytic Leukemia Due to (or as a consequenca of): Due to (or as a consequenca of):												
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50 2													
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igned by the a be detached if by Physic	Transient Ischaemic Attack								1 Yee 2 No 3 Probably				
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has pe 2 s											of	death?	
s certificate has been si director, page 2 should To Be Completed	RAPSALL CLA								10	Yes 2 No	11	Yes X No	
certificate rector, pag	25. Wes case referred to medical						26. Plac	e of Deat	ath (Check only one)				
0 = 0	exeminer?	Hospitel: 1 Ing	atient 2 FR/	Outnatien	nt 3 DO	A Oth	er: 410 N	ursing Ho	me 5∏Res	idenca 6 □Ot	her (Speci	(v)	
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rs after death. al Director: After thised in by the funeral Certification:	tX Neturel 5 ☐ Pending	(Month,	Dey Year)	Injury	м			No					
death ctor: / y the f y the f	2 Accident							296 Location (Street and Alumber or Pure) Pouts Alumber					
after deat Director: d in by the ertifical	4 ☐ Homicide determine	building	28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)					28f. Location (Street end Number or Rural Route Number, City or Town, State)					
S = 0													
une by fi	29a. Certifier (Check only (Check only 2) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner as stated.												
within 24 hours at To the Funeral D completely filled is	one)	and manne	r steted.		. Jongolion,	y C	P.11.011, U61	000011	- o gr tird tirde	, 3010 0110 p1008	, 2 300 (
within 24 hours a To the Funeral D completely filled i	29b. Signature and title of cartifier 29c. License number							29d. Date signed (Month, Dey,			Dey, Year)		
	Margares V. Posery D 47330							November 2 2000					
10	B 47530								November 2, 2000				
	30. Neme and address of person who completed cause of death (Nem 23a) (Type, Print) Thomas V. Joseph, MD 50 W. Edmonston Drive, Suite 207, Rockville, MD 20852												
					Drive	, Sı	iite .	207,	Rockvi	lle, MD	2085	2	
State	31. Dete filed (Month, Day, Year)		istrer's Signature	6	1	./							
Registrar	NOV 03	2000	una	D.	ppo	uns							

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 29, Enrique A. Chacon October 2000 11:45 PM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner | Silver Spring Holy Cross Hospital Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Deys Hours Min. 1X M 2□ F Yrs. Director 075-26-9262 75 January 23, 1925 Costa Rica Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County than "natural", or flams 23s or 20s-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo Maryland Montgomery Bethesda 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5304 Yorktown Road 20816 United States Funeral 14. Rece - American Indian, Bteck, White, etc. 12. Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritet Stetue Armed Folicit

1 ☑ Yes 2 □ No
If Yes, Give Korean
Yeer or Detes: Conflict filed within 72 hours after 1 ☐ Never Merried 2 ☑ Merried Baltimore, Maryland 21215-0020 1⊠Yes 2□No Specify: Costa Rican by Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry United States Elementary/Secondery (0-12) College (1-4or 5+) 5+ Government Revenue Officer 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Pages 1 and 2 should be filment of Health and Mental Hant: If Nem 27 is marked off Be 7 is marke fraumatic Roger Chacon Tulia Canton 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Lastenia Z. Chacon/Wife 5304 Yorktown Road, Bethesda, Maryland 20816 20b. Ptece of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, Stete Silver Spring, 20e. Method of Disposition November November ò 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 2, 2000 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Maryland 22. Name and Address of Facility Robert A. 21. Signeture of Funeral Service Licensee Pumphrey Funeral Home/ my ir Rockville, Inc., 300 West Montgomery Avenue, M01126 Rockville, Maryland 20850-2805 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feliure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Sepsis Examiner Due to (or es a consequence ot): Physician/Medical Examine The law requires that the death certificate be executed Sequentietly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last use as the burial-tran Due to (or es e consequence ot) Box 68760, Due to (or es e consequence of): P.O. sate has been signed by the a page 2 should be detached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yas 2 No of Vitai Records, Be Completed by 24b. Were autopsy tindings evailable prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 Yes 2 No certificate or Attending Physician: 25. Was case referred to medicat 26. Place of Deeth (Check only one) Hospitel: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Certification: To 1 Yes 2 No this 28c. Injury at Work? 27. Menner of Death 28b. Time of 28d. Describe how Injury occurred Atter Division 1 Natural 5 Pending after death. 1 Yes 2 No investigetion 2 Accident the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pieca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated.

2 Medical Examinar: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier Medical completely (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifie 29c. License number D42518 October 30, 2000 20+ 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 11119 Rockville Pike #316, Rockville, Maryland 20852 Gul Chablani, M.D. 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State Beneva 2000 NOV 03 Registrar

DHMH 16 Ray 6/95



00-6146-031

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

CHARLES	
CHYDDANIA	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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0	~	1	1	0

Þ	Physician
8	/Medical
	Examiner

1. Decedent's Nama (First, Middle, Last)

Cardany

12. Was Decedent Evar in U,S. Armed Forcas?

5+

OCTOBER 28,2000

GERMANTOWN

If Undar 1 Yaar | If Undar 24 Hrs.

20876

Days

4h. City. Town, or Location of Death

3. Time of Death 2:20P.M.

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F	une	ra
ח	irec	to

Director

Funeral

Be Completed by

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at or items ; filed within 72 hours after Hygiena. permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 Is marked oth any Injury or other traumatic event

Baltimore, Maryland 21215-0020

Charles Russell 4a Facility Nama (If not institution, giva street and number) 21515 WATERS DISCOVERY TERRACE 5. Social Security Number 1**∑** M 2□ F 220-42-1987 Usual Rasidence of Decedent 10a. Stata 10b. County Md. Montgomery

10e. Street and Number

11. Marital Status

10c. City, Town or Location Germantown

Yrs.

7. Aga (In yrs. last birthday)

55

8. Date of Birth (Month, Day, Year) Hours

2. Data of Death

Month

 Birthplaca (Steta or Foraign Country) Florida 10d. Inside City Limits

1 Yas 2V No

10f. Zip Coda

United States Was Decedant of Hispanic Origin? (Specify Yas or No-iff Yas, specify Cuban, Maxican, Puarto Rican, atc.)

14. Race - American Indian, Black, White, etc. Specify: White

10g. Citizen of What Country?

4c. County of Death

MONTGOMERY

1 ⊠Yas 2 No 1973-3 ☐ Widowed 4 🗓 Divorced Yaar or Datas: 15. Decedent's Education (Specify only highast grada complated)

Collega (1-4or 5+)

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) Physician/Cosmetic Surgeon

16b. Kind of Businass/Industry

17. Fathar's Nema (First, Middla, Last) George J. Cardany

Elamentery/Secondary (0-12)

1 Nevar Marriad 2 Married

Vogt Hazel

Medical 18. Mothar's Neme (First, Middla, Maidan Surnama)

19a. Informent's Name/Ralationship (Type, Print)

19b. Meiling Address (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Code)

Marie Cardany (Sister in Law) 20a. Method of Disposition

1 Burlal 2 □ Cramation 3 □ Ramoval from Stata

21515 Waters Discovery Terrace

20b. Place of Disposition (Nama of cematary, cramatory or other place) Gate of Heaven Cemetery

302 Park Ave. Mt. Airy, Md. 21771 20c. Location - City or Town, Stata Data Nov. 2, Silver Spring, Md. 2000

21. Signature of Funaral Sarvice Licensee eitles

4 ☐ Donation 5 ☐ Othar (Specify)

22. Nama and Addrass of Facility DeVol Funeral Home

10 East Deer Park Dr. Gaithersburg, Md. 20877 Approximata Interval Batween Onsat and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heart failure. List only one cause on each line.

Physician /Medical **Examiner**

that the death certificate be executed

The law requires

Hospital or Attending Physician:

To the

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Completed

Be

Certification: To

been signed by the should be detact

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Affer

the

efter death.

within 24 hours

20

Box 68760.

P.O.

of Vital Records.

Division

Physician/Medical Examiner Sequentially list conditions, if any, laading to immadiate causa. Entar Underlying Cause (Disaase or Injury that initiated events thet initiated events rasulting In death) Last

Immediata Causa (Final diseasa or condition rasulting in daath)

Dua to (or as a consequance of)

Due to (or as a consequence of)

Dua to (or as a consequence of)

Part II. Other aignificant conditions contributing to death but not rasulting in the underlying cause given in Part I.

23b. Did tobacco use contributs to the cause of death? 2 No 1 Yes 3 Probably 4 Unknown

24a. Was an autopsy performed'

111 Penn Street, Baltimore, Maryland 21201

24b. Wara autopsy findings available prior to completion of cause of death?

Yas 2 No

25. Was casa rafarred to medical 1 Yes 2 No

Hospital: 1 Inpatiant 2 ER/Outpetient 3 DOA 28b. Time of Injury

26. Plece of Deeth (Check only ona)

Other: 4 Nursing Homa 5 Residence 6 Dother (Specify) CENE 28d. Describe how injury excurred
Subject in fole
Exforms T auto

2 No

6 Could not be datarmined 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) PARACE AT HOME

Funes Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier

27. Manner of Death

1 Natural

2 Accident

30 Suicida 4 Homloida

1 Certifying Physician: To the best of my knowledge, death occurred at tha time, data and place, and dua to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signarity and title of certif

5 Pending invastigation

O.C.M.E.

29c. Licansa number

1 Yes

OCTOBER 29,2000

29d. Data signed (Month, Day, Year)

Registrar

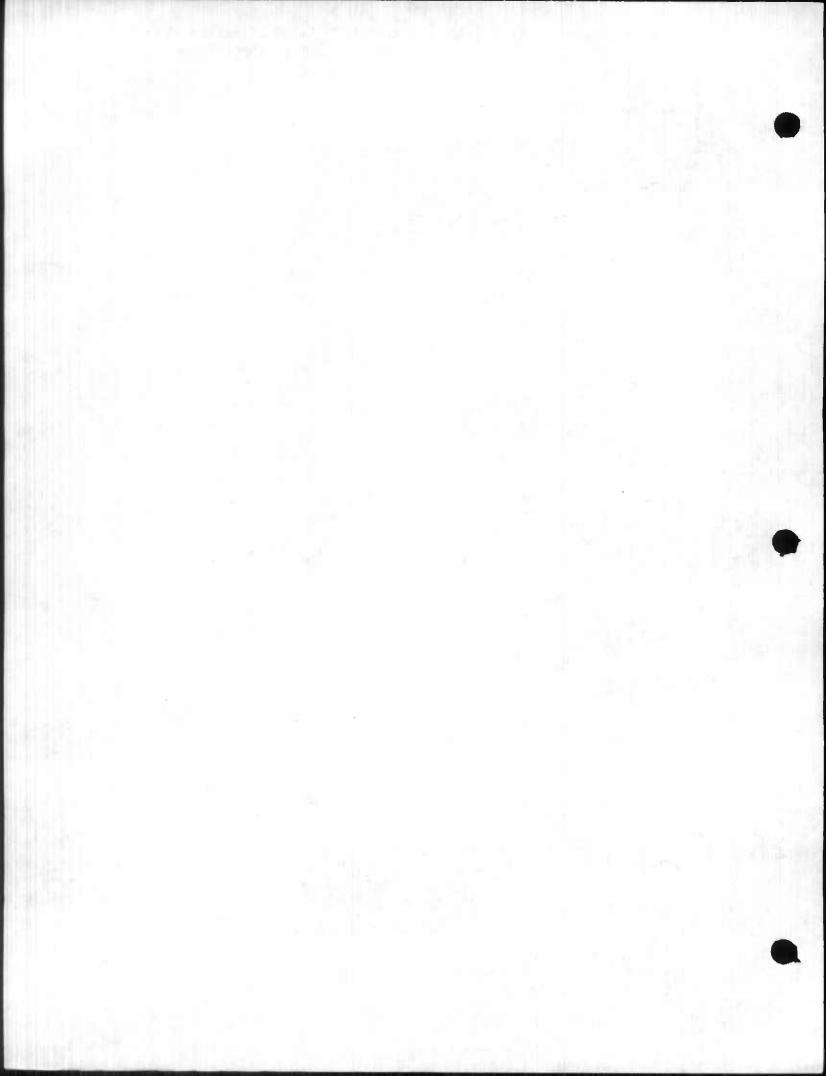
Data filed (Month, Day, Year) 31

ARCH

ND 32. Registrar's Signatura

who completed causa of daath (Item 23a) (Type, Print)

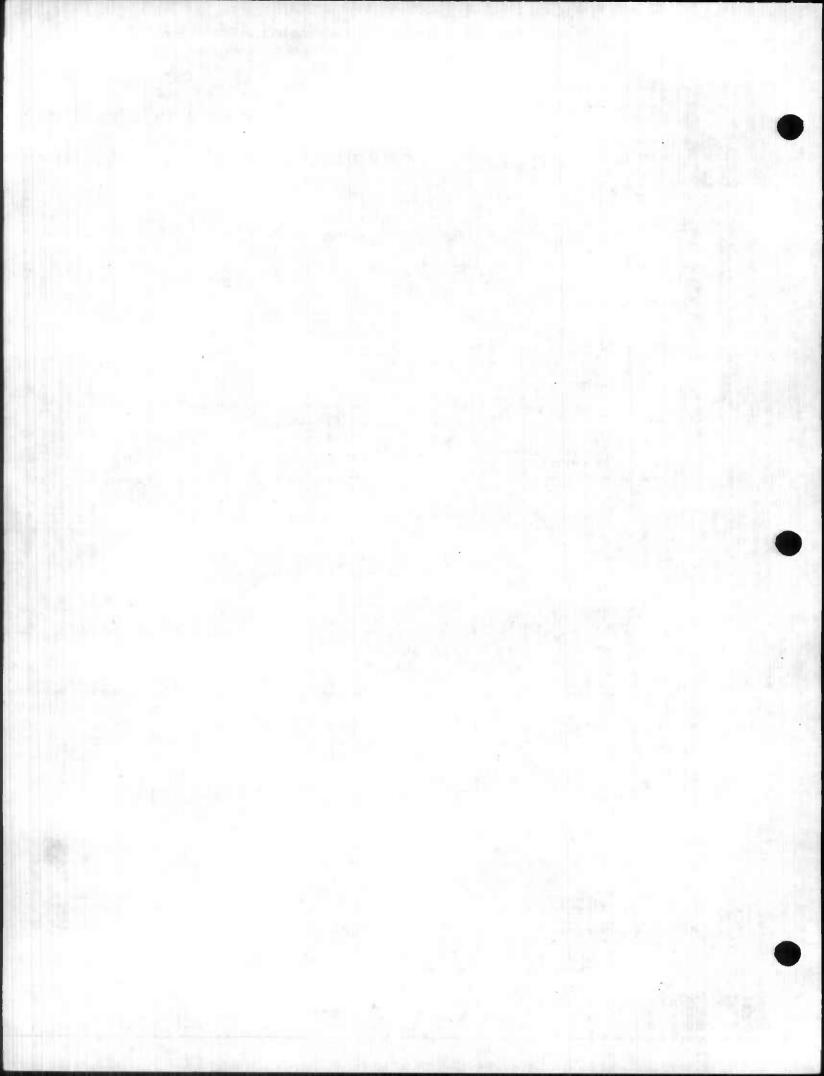
DHMH 16 Ray 6/95



		State of Marylar		tificate of			Reg. No.	0 36	5/47			
Physician	1. Decedent's Name (First, Middle, Last Carol Sue Cahil					2. Dete of Dec Month	Dey	Year 3.	Time of Death			
/Medical	A - F - 100 N 106 A				4b. City, Town, or Lo	Octobe:			1:10 AM			
Examiner	Frederick Memoria				Frederi		Frede					
Funeral Director	320-13-3300	x	last birthday) Yrs.	If Under 1 Year Months Deys	If Under 24 Hrs. Hours Min.	8. Date of Birt July 2	Y 1953	9. Birthplace Country) Arizon	(Stete or Foreign			
fand and	Usual Residence of Decedent 10a. Stete 10b. County	10c. C	ity, Town or Lo	cation				10d. I	nside City Limits			
or the Maryland or 28ef show a notified at	Maryland Frederick	I	rederi	ck					Yes 2 No			
th with the Ma 23s or 28s-fr ast be notified				10f. Zip Code 21701		10g. Citizen of What Country United States						
DOSO Ours after death with the Maryle Exemples 23e or 25e-f also Exemples mast be possibled at the Funeral Director	3 ☐ Widowed 4 ☑ Divorced	12. Wes Decedent Ever in L Armed Forces? 1 Yes 2 No If Yes, Give X Yeer or Detes:		Vas Decedent of H Yes, specify Cub ☐ Yes 2☐No	lispanic Origin? (Spe en, Mexican, Puerto Specify:				te			
be filed within 72 hours at lai Hygene. d other than "netural", or vever, the Medical Exam Ba Completed by 8	15. Decedent's Edu (Specify only highest grad Elementary/Secondery (0-12)				eation during most of worki d)				У			
	12		Ca	shier		Retail						
42 should be fire th and Mental Hy 7 is marked othe traumatic event	17. Father's Neme (First, Middle, Last) (unknown)				18. Mother's Neme	(First, Middle, rine Ri		10)				
2 sho	19e. Informent's Name/Reletionship (7) Lisa Marie Cahill	ype, Print) / Daughter			and Number or Rura			Stete, Zip Coo	de)			
0 TO NO 14	20a. Method of Disposition	20b.	Plece of Dispos	sition (Name of	Frederick	Dete Dete	1701 20c. Location -	City or Town.	Stete			
milt. Pages 1 at partment of Hea portant. If them? y injury or other 26.	1 ☐ Burial 2 ☐ Cremetion 3 ☐ F 4 ☐ Donetion 5 ☐ Other (Specify)	Removel from Stete	esthave:	n Cremat	ory	0-27-0)Frederi	lck, Ma	ryland			
Department of the poor of the	21. Signature of Funeral Service Ligens	90		. Name end Addre	es of Fecility Skl ne Ct. Bal				rtician)			
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Due to (or es e consequence of):											
cate be executed physician and the bunal-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury C.											
	Cause (Disease or injury that initiated events resulting in death) Lasf Due to (or es e consequence of):											
ss that the death certific goed by the attending p be detached for use as by Physician/Me	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death											
at the d by the etache		certs. Other significant conditions contributing to death out not resulting in the underlying cause given in Pert I.										
require been s should					24e. Wes	an autopsy med?	availat	autopsy findings ble prior to etion of cause				
The law ate has b page 2 s						10	Yes 2 No		es 2 No			
certificate rector, pag	25. Was case referred to medical exeminer?				28. Place of Deet		/-					
Physician: This certification, principle Control of the Control of		Hospitel: 152 Inpatient 2	ER/Outpatien	t 3 DOA Ot	ner: 4 Nursing Ho	me 5 Resi	dence 8 Oth	er (Specify)				
Attending Pt or death. ector: After th by the funera		28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury	Wo	ry ef rk? Yes 2 No	28d. Describe	how injury occur	red				
or Attending after death. I Director: After d in by the fune	3 Suicide 6 Could not be 4 Homlcide determined	28e. Plece of Injury - At I building, etc. (Speci		eet, fectory, office		28f. Location (. City or To	Street and Numb vn, Stete)	per or Rural Ro	oute Number,			
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has complately filled in by the funeral director, page 2. Medical Certification: To Be Comp	29a. Certifier 1 Certifying Phy (Check only one) 1 Medicat Exami	sician: To the best of my known on the besis of examinating and manner stated.										
To th To th comp	29b. Signature and life of certifier	Jen		29c. Licens	44213		29d. Date signe	d (Month, Day	(, Year)			
	30. Name and address of person who of				(Darri V	701 cm						
State	198 Thomas Johnson 31. Date filed (Month, Day, Year)	32. Registrar's Sign	eture	1	(Ravi Y	alamano	chili, M	<u>, (m</u>				
Registrar	OC 3 0	2000		1								

DHMH 16 Rev 6/95

ORIGINAL



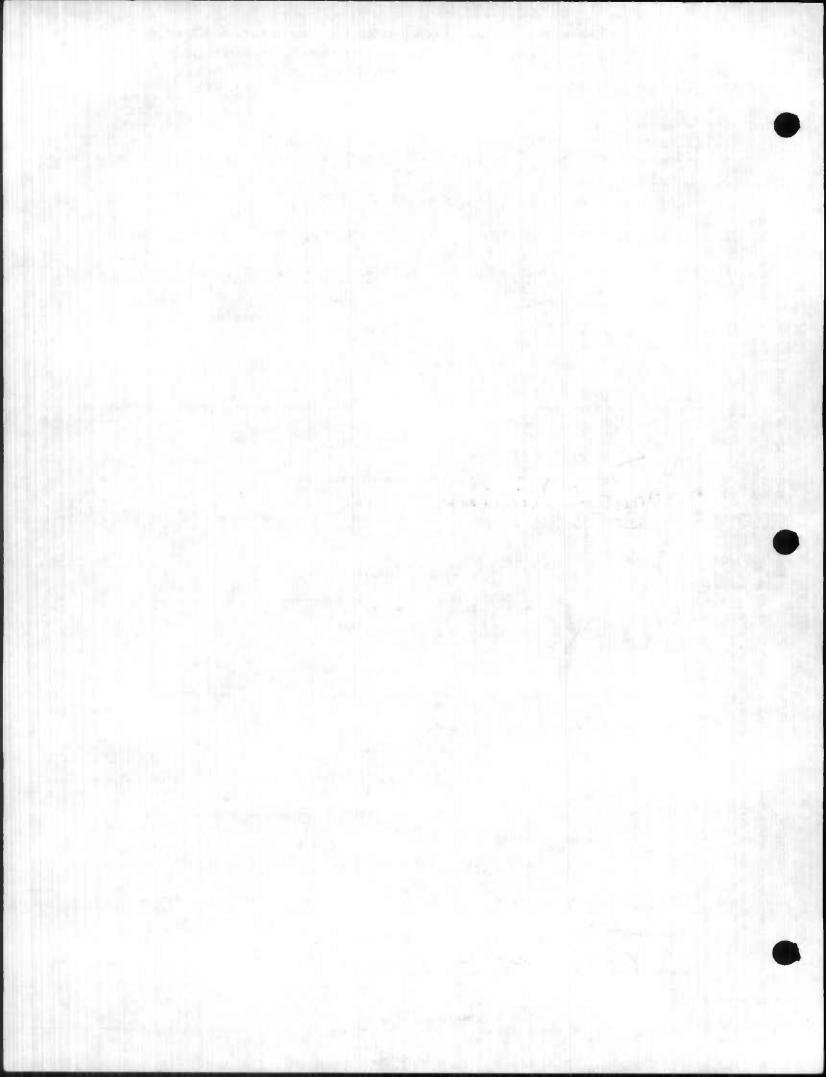
State of Maryland / Department of Health and Mental Hygiene 00 36148

				Cer	tificate of	Death		Reg. No.		00,40
	- 4 5.5	1. Decedent's Name (First, Middla, Last)				2. Date of Month		Year	3. Tima of Death
	Physician /Medical	James Ma:	rtin Cassel					er 18, 20		16:59
7	Examiner	4a Facility Name (If not institution, giva SHADY GROVE AD	ericas y militaria	SPITAI		4b. City, Town	n, or Location of Do		of Death	C RY
	Funeral Director	5. Social Security Number 6. Se 176–09–5667		i. last birthday) Yrs.	If Under 1 Year Months Days		4 Hrs. 8. Date of (Month,	Birth Day, Year)	9. Birthpl Count	lace (State or Foraign try) Pennsylvan
	Maryland 4 show led at	Usual Residence of Decedent 10a. State 10b. County Maryland Montgome		ity, Town or Lo					10	0d. Inside City Limits 1 ☐ Yes 2 No
	her death with the Marylar litera 23a or 28a-f show liter must be notified at Furneral Director	10e. Street and Number 12205 Sunnyview Di			10f. Zip Code 20876	19		10g. Citizen of V	What Count	try?
020	ar, or	11. Marital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Agned Forces? 1 2 Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of It If Yes, specify Cub		n? (Specify Yes or Puerto Rican, etc.)	No- 14. Rac Blac Specify	ce - America ck, White, e	
Maryland 21215-0020	within then be Me	15. Decedent's Edu (Specify only highest grad Elamantary/Secondary (0-12)		(Giva lifa. L	dent's Usual Occup kind of work dona DO NOT usa retire	during most of	of working	16b. Kind of B		
land 2	Mental Hygin Mental Hygin Menta	17. Father's Name (First, Middla, Last) Floyd Fernwell	Cassel				s Name (First, Mid	dle, Maidan Suman	na)	
ary	N post	19a. Informant's Neme/Relationship (T)		19b. Mailin	ng Address (Street	and Number	or Rural Routa Nu	mber, City or Town,	Stata, Zip	Coda)
250	and 2 27 is	Katherine G. Casse				iew Dri	ive, Germ	antown, N	laryla	and 20876
Baltimore	Pages 1 ant of He of if item ry or oth	20a. Method of Disposition 1 Burial 2 Cremetion 3 F 4 Donation 5 Other (Specify)	Removal from Stete	cematary, cran	sition (Nama of natory or other pla I tan Cres		Date 10/20/	20c. Location -		wn, State La, Virgini
Balti	Departm Departm Importar any Inju	21. Signature of Funeral Service Licens) 01	Name and Addre	ss of Facility leswor	th P.A.,	Funeral	Home	
	Physician	23a. Part1. Anter the disease, or compleshock,	ications that caused the deen e cause on each line.	oth. Do not anti	ar tha mode of dyi	ng, such as co	erdiac or respirator	cus, Mary y arrast,	Land	20872-011 Approximata Interval Between Onset and Death
	/Medical Examiner	Immediate Cause (Final disease or condition rasulting in daath)	Ventricula Due to	ar Fibe						Seconds
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s, P.O.	the de ached hysic	Part II. Other eignificant conditions cor	tributing to death but not re	sulting in the u	nderlying ceuse gi	ven in Pert I.		Old tobacco use co		the cause of death?
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æ	lcian: The lav certificate has rector, page 2	O'THE STATE					1	☐ Yes X☐ No	10	Yes 2□ No
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ion	or Attending Phater death. Director: After th I in by the funeral	27. Manner of Death 1 Naturat 5 Pending 2 Accident investigation	28a. Data of Injury (Month, Day Year)	28b. Time of Injury	Wo	ryat rk? ∣Yes 2 🗆 N		be how injury occur	rea	
DIX		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, atc. (Spec	home, ferm, str ify)	eet, factory, office		28f. Location City or	on (Street and Numl Town, Stata)	ber or Rura	I Routa Number,
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DHMH 16 Rev 6/95

Registrar

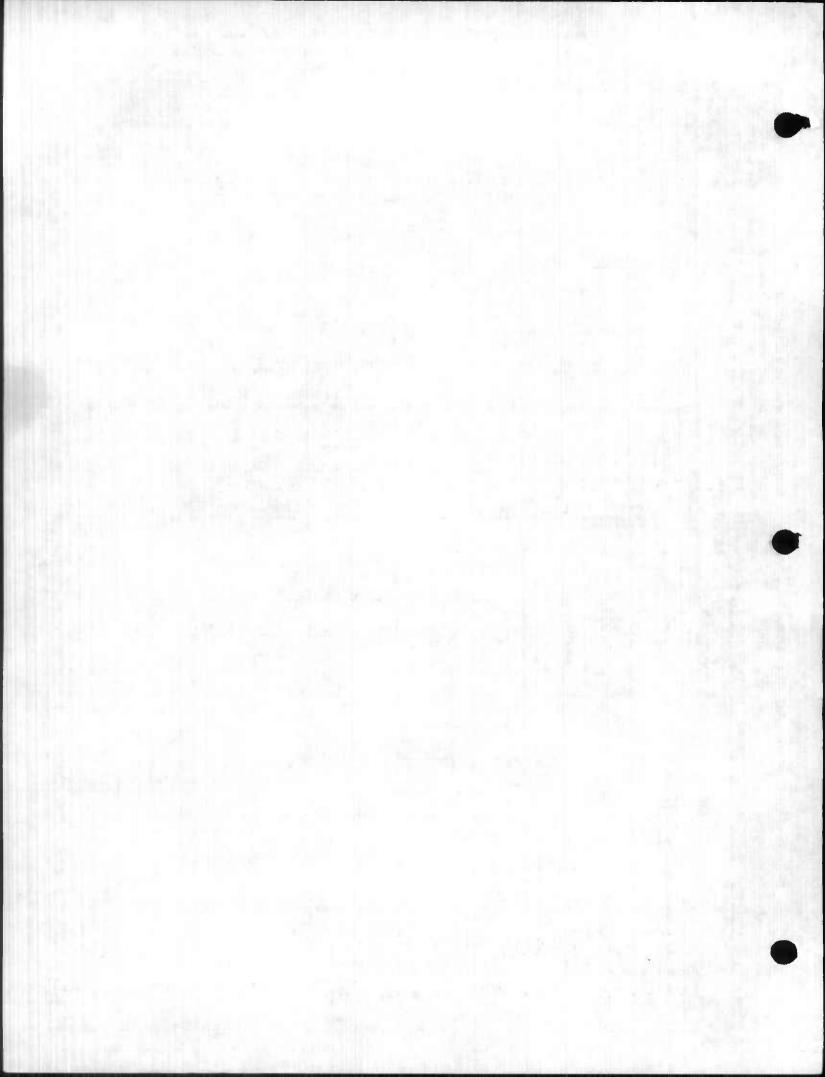
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State of Maryland / Department of Health and Mental Hygiene

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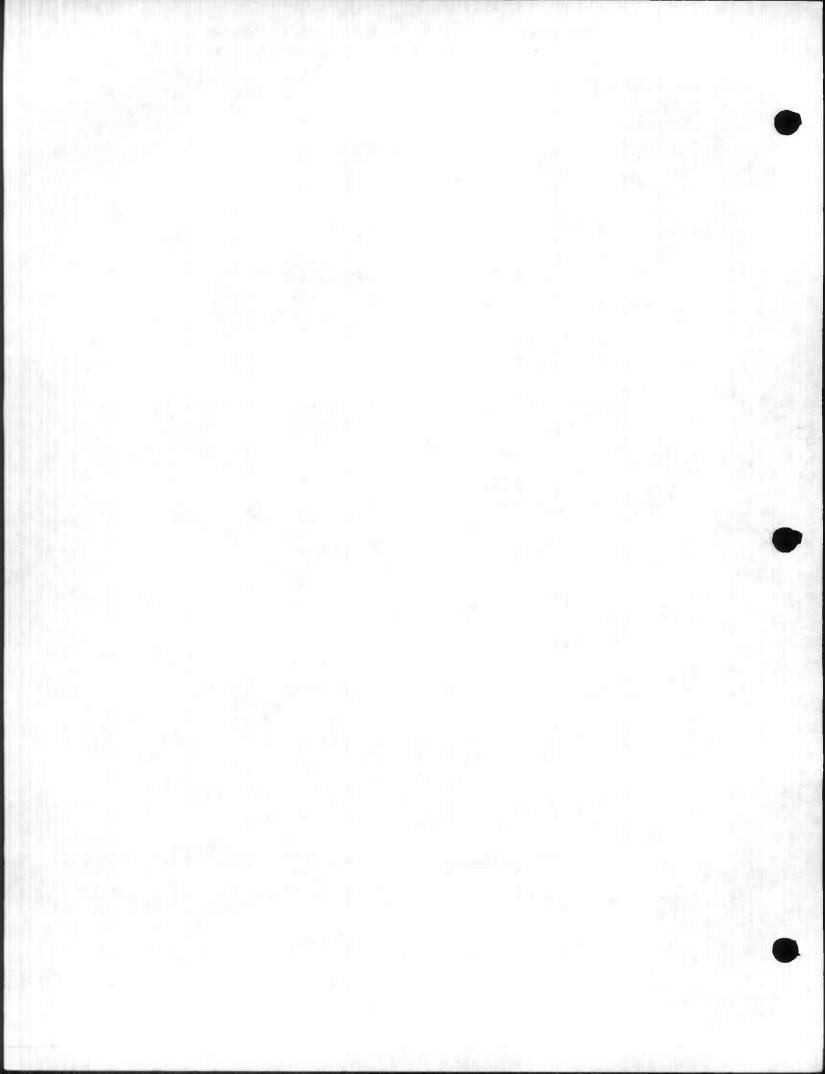
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State of Maryland / Department of Health and Mental Hygiene

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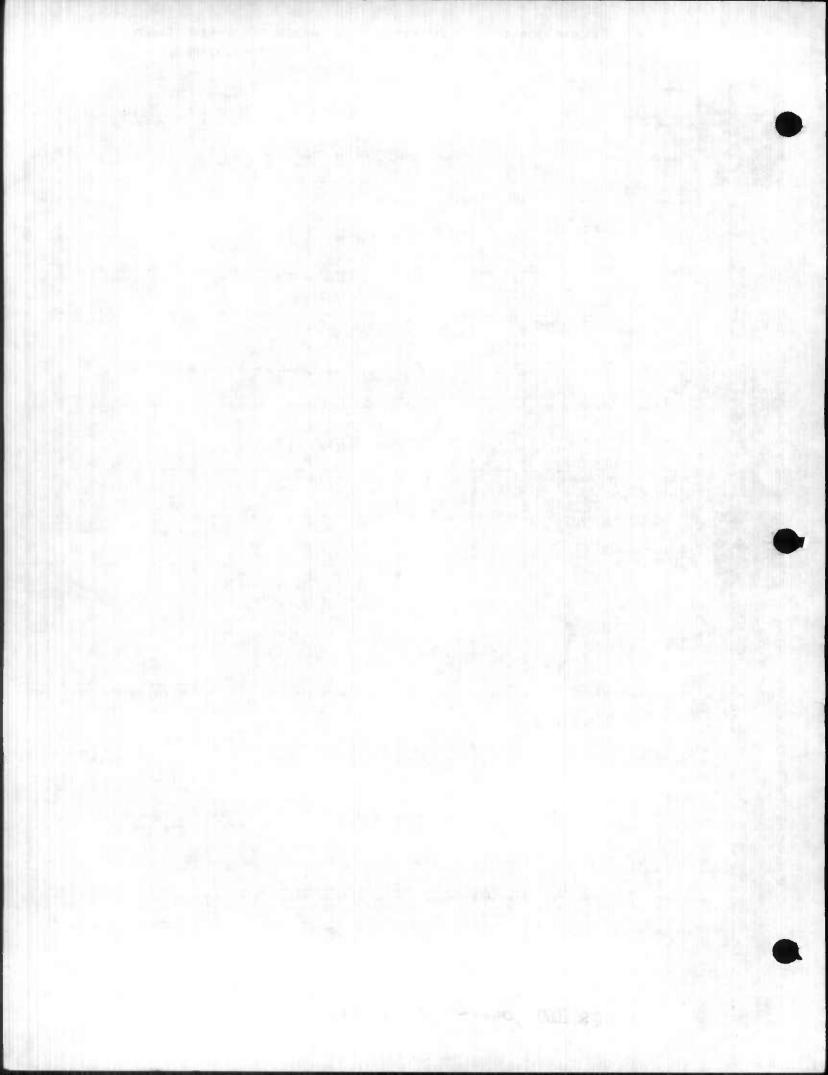
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	/Medical Examiner	4a Facility Neme	(If not institution, give	e street and number,)			4b. City, To	own, or Loc	ation of Deet	4c. Count	y of Death		-
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Of Physi	ig P		No	1 Minpati			3□ DOA		-		dence 6 🗆 O		fy)	
L 00		27. Manner of De 1 Neturel	5 Pending	28e. Dete of Inj (Month, De	ay Year) 28	b. Time of Injury		njury at Work?		28d. Describe	how injury occu	irred		
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State of Maryland / Department of Health and Mental Hygiene 00 36151

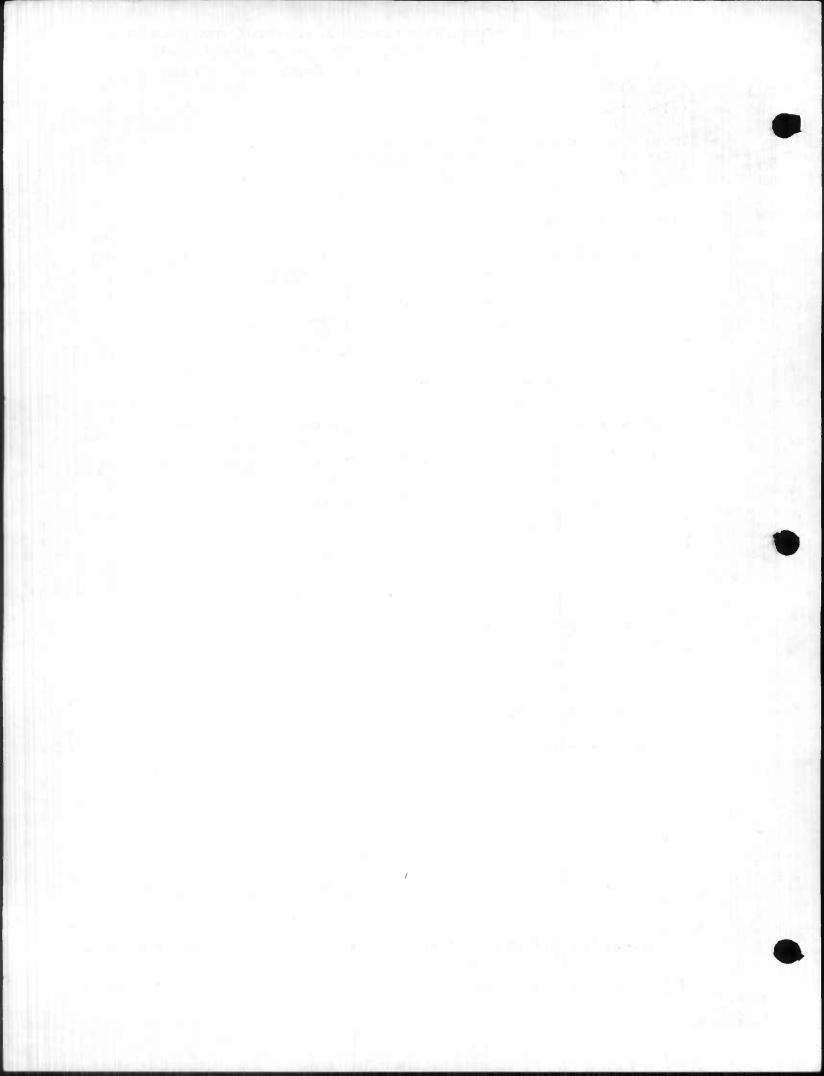
			Ce	rtificate	of Death		Reg.	No.	U	0131	
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Examiner	4e Facility Neme (If not Institution, give	and the same of th					mon or beam				
Funeral Director	Maplewood Park P1 5. Sociel Security Number 6. Se 271–18–1461	7. Age (In yr	7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs. Months Deys Hours Min.					8. Date of Birth 9. Birtholace (Ste			
2	Usuel Residence of Decedent										
T Line	10a. Steta 10b. County	10c. 0	City, Town or L	ocation					10	d. Inside City Limit	
or 28a-f. be notified	Maryland Montgome	ry Be	thesda							TO THE ZALIN	
or 2	10e. Street and Number			10f, Zip Co	de		10g.	Citizen of Wh	at Countr	ry?	
23s unt	9707 Old Georgeto	wn Road #230:	3	2081	.4		US	SA			
hours after death with the Maryla burst, or Heme 23s or 28s-1 sho at Examiner must be notified at ad by Funeral Director	11. Marital Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorcad	12. Wes Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:	U,S. 13.	Was Deceden If Yes, specify 1 ☐ Yes 2 ☑	t of Hispanic Orig Cuben, Mexicen No Specify:	gin? (Speci , Puerto Ri	fy Yes or No- can, etc.)	14. Race- Bleck, Specify:	White, el	tc.	
72 ho	15. Decedent's Ed		16a. Dece	edent's Usuel C	ccupation		16	b. Kind of Busi	ness/indu	ustry	
ed within 72 ho ygiene. Ygiene. It the Medical.	(Specify only highest grad	de com <i>pleted)</i> College (1-4or 5+)	- (Give	DO NOT use i	lone during most etired)	of working					
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Ments bearing by the state of t	Walter Murray				Nora	Heek	in				
SEE.	19a. Informant's Neme/Reletionship (T	ype, Print)	19b. Meil	ing Address (S	treet end Numbe	er or Rurel	Route Number, C	ity or Town, S	tete, Zip (Code)	
and 2 setth a ar trap	Ellen D. Murphy /	Daughter	1140	8 Sene	a Fores	t Cir	cle, Ger	cmantow	n, M	D 20876	
-255	20e. Method of Disposition	20b	Pleca of Disp	osition (Name emetory or othe	of r place)		Dete 20	c. Location - C	lty or Ton	m, Stete	
Pages nert of any or o	1 Burlel 2 Cremetion 3 4 Donetion 5 Other (Specify	Hemovei from Stete			ematory	11	/2/00 AI	Lexandr	ia,	VA	
Department Pa Department Important any Injury ance	21. Signeture of Funerel Service Licens	IRO					uneral H			10 000	
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/Medical Examiner	disease or condition resulting in deeth)	Esophagea Due to Strokes	Cance						1		
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death e atte ed for	Pert II. Other eignificant conditions co	intributing to death but not re	esulting in the	underlying caus	se given in Pert I.		23b. Did toba	cco use cont	ribute to	the cause of deat	
es that the death ce igned by the attendi be detached for uss by Physician/							1 Yee 2 No 3 Probably				
been s should		PACE					24e. Wes en e performe		ave	re eutopsy findings iteble prior to apletion of cause eath?	
0 - 0 =							1 ☐ Yes	2 No	1 🗆	Yes 20 No	
certificate rector, pa	25. Wes case referred to medical				26. Plece	of Death	(Check only one)				
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Attending Phy or death. ector: After this by the funeral of lification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Dey Year)			Injury at Work?	28	d. Dascribe how				
Lal or Attending P rs after death. In Director: After t led in by the funers Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Pleca of Injury - At building, etc. (Special Control of the C	home, ferm, si	treet, fectory, o	ffice	28	of. Location (Stree City or Town, S	et end Number State)	or Rural	Route Number,	
in 24 hours in 24 hours he Funer pletely fill edical	29a. Certifier (Check only one) 1 Certifying Physics 2 Medical Example 1	reician: To the best of my ki iner: On the basts of exami- and menner steted.	nowledge, dee netion end/or in	th occurred at investigation, in	he time, dete en my opinion, dee	d placa, en th occurred	d due to the caus d et the time, date	se(s) end men e end placa, ar	ner as sta nd due to	ited. the cause(s)	
Within To the comp	29b. Signeture end title of certifier			29c. L	icense number		29d	. Date signed	(Month, D	Pay, Year)	
30	CK/e	uly	1	D	26259		No	vember	2,	2000	
	30. Nema and address of person who c	ompleted cause of death (It	em 23e) (Type	, Print)							
	Ava A. Kaufman, M				sda. MD	208	14				
State	31. Dete filed (Month, Dey, Year)	32 Registrer's Sig		, Decine	Juay III	200					
State Registrar	MOV 0 9' 200	1) Denve	B.	Spour	w						

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 36152

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Exami	ner				- 0								
		Brooke Grove Rehal					nder 1 Yaar	01n			ntgome		
Funeral Director		5. Social Security Number 6. S. 577-24-5690 Usual Rasidanca of Decedent	mx □M 2K0 F	7. Aga (In yr		mont Mont				1909	9. Birthpi Count Virgi	ace (Stata or Fore ry) Lnia	
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s 23	grai	6207 Wedgewood Roa			11.0	10 111 -	208			United			
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4 DEE	-	19a. Informent's Name/Ralationship (7	ype, Print)		19b.	Malling Add	ass (Stree	t and Number or F	Iural Routa Numbe	r, City or Town	State, Zip	Coda)	
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Heelth Heelth tem 27		20a. Mathod of Disposition	ni, oddi			Disposition (Data	20c. Location			
P T T		1 Burial 2 Cramation 3							Oct. 28				
rtani njun		4 ☐ Donelion 5 ☐ Other (Specify 21. Signature of Funaral San License		C.	nesap	eake	orella	tory Inc	2000 app Funer	Belts			
permit. Pages 1 and 2 Department of Heelth Important: If Item 27 i any injury or other tra		Stalu A	Phys	nen	~	Stephe	en D.	Lohrmani				on serv.	
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		30. Name end addrass of person who c	omplated caus	se of daath (Ita	am 23a) (T	ype, Print)							
				12 124	Sc	GROVE	ia de	enve 6	Jank.	mo	2090	2)	
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		State of Ma		ertificate of			Reg. No.	361	53
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Examiner	4e Facility Neme (If not institution, g	give street end number)			4b. City, Town, or L	ocation of Death	4c. County	of Death	
		N ADVENTIST	HOSPITAL		TAKOMA			TGOMERY	
Funeral Director	5. Social Security Number 126–22–3952	Sex 7. Age	(In yrs. last birthde) Yrs.	Months Days	Hours Min.	8. Dete of Birth (Month, De) NOV • 4	v. Year)	9. Birthplece (S. Country) TENNES	tate or Foreign
pur .	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	ocation				10d Insi	Ide City Limits
aho aho			700. O., 70701						Yes 2□No
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leath	2200 COLUMB:	IA PIKE #71			22204 Hispanic Orlgin? (Sp	pecify Yes or No-		S.A. - American India	an,
Med yieling 2 I.Z.13-0020 I should be filed within 72 hours after death with the Maryland I should be filed within "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	1 Never Married 2 Married 3 MWidowed 4 Divorced	Armed Forces?	WWII	. Wes Decedent of H If Yes, specify Cub 1 ☐ Yes 2 💆 No		Rican, etc.)	Specify.	k, White, etc. WHITE	
A LE 13-0020 d within 72 hours at giene. r than "natural", or r Wodfel Extra completed by I	15. Decedent's	Education	16a. Dec	edent's Usuel Occup	pation		16b. Kind of Bu		
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De file d'othe event,	17. Father's Name (First, Middle, La	ist)			18. Mother's Nem	e (First, Middle,	Meiden Sumem	e)	
Ment Ment build bu	JOSE	BENIGNO	DeCASTRO		LY	DIA	KAUF	MANN	
Marytand 42 should be file h and Mentel Hy 7 is marked othe traumatic event,	19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	ling Address (Street	end Number or Ru	rel Route Numbe	or, City or Town,	Stete, Zip Code)	
and and n 27 h	JUNO Y. AUGUS	TINE/SISTER	720	4 CEDAR A	VE., TAKO	MA PARK	, MD. 20	912	
-155	20a. Method of Disposition 1 ☐ Burial 2 M Cremation 3	TRamoust from State	20b. Placa of Disp cemetery, cr	oosition (Neme of emetory or other pla	ice)	Date	20c. Location -	City or Town, Sta	ite
Dearth Pages Department of Important: If its any injury or o	4 Donation 5 Other (Spe		CHAM	BERS CREM	ATORY	11/2/00	RIVEF	DALE, M	D.
Physician /Medical Examiner Examiner	23a. Pert1. Enter the disease, or co shock, or heert feilure. List on Immediate Ceuse (Finel disease or condition resulting in death)	e. Palvn	the deeth. Do not e	Embol	ng, such es cardiec	or respiratory ar	rest,	Approx	xImete el Between and Death
cate be ohysicie the bu	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Last	C	Oue to (or es e consi						
at the death certification the death certification of the estending pateched for use es									
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been s should						24a. Was perfo	en autopsy med?	24b. Were auto avellable p completion of deeth?	
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vitali dician: The certificate rector, pag	25. Was case referred to medical				26. Plece of Dea	th (Check only o	ne)		
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T PHE T	3 Suicide 6 Could not determine		ry - At home, farm, s (Specify)	street, fectory, offica		28f. Location (S City or Tox	Street and Numb vn, Stete)	er or Rural Route	Number,
To the Hospital or within 24 hours after To the Funeral Director completaly filled in Medical Cert		Physician: To the best of caminer: On the basis of and menner stat	examination end/or						use(s)
Withing A comp	29b. Signeture end title of certifier	my).A	Handing M Emergen	1D 29c. Licen.	se number 4845		29d. Date signed	d (Month, Day, Ye	ear)
	30. Name and address of person who Humay un Zey,	no completed cause of de	eth (Item 23e) (Type Washing to	in Advent	vist Hospit	ol, Tale	oma Por	k, md.	
State Registrar	31. Date filed (Month, Dey, Year)	32. Registre	is Signature	Sports					

DHMH 16 Rev 6/95

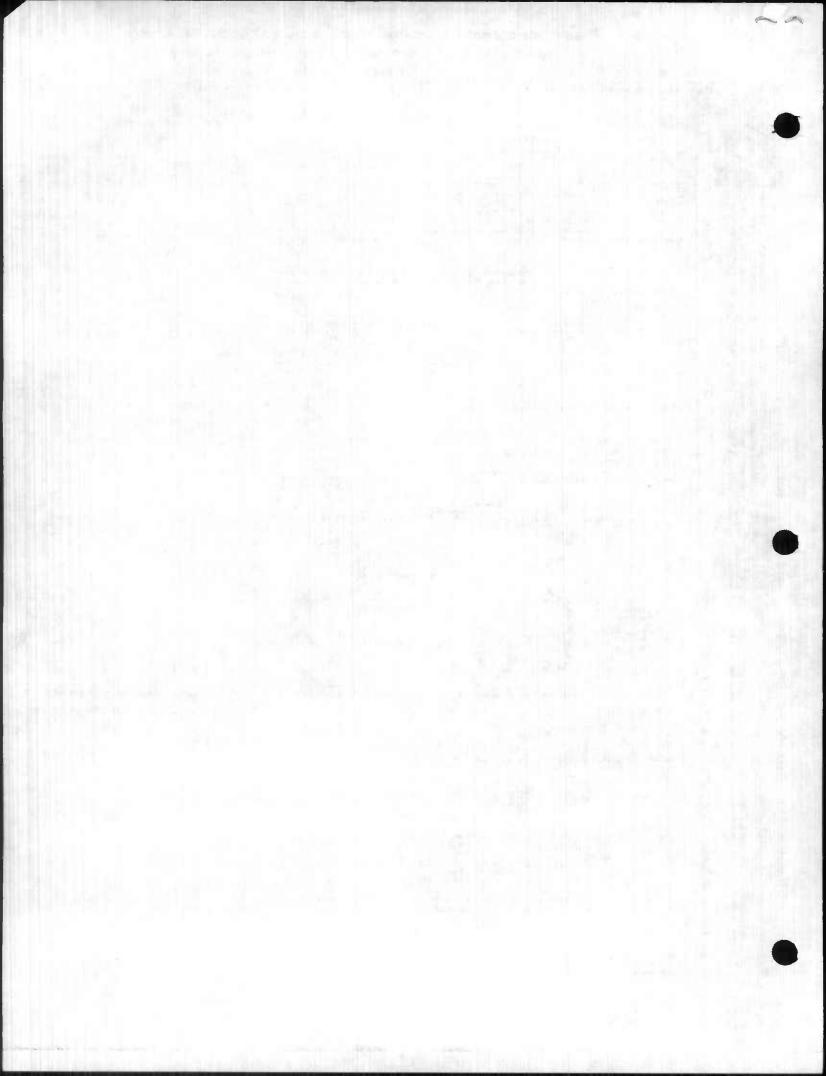
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State of Maryland / Department of Health and Mental Hygiene

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	miner	4e Facility Neme (I				TO THE			4b. City, Town,	or Location of Deet	th 4c. County	of Death	
		Mariner	Health	of Kens:	ington				Kensing		Monte	gome	cÀ
Fune Direc		5. Sociel Security N 167-22-6	6984	6. Sex 1 ☐ M 2 ☐ ¥F	7. Age (In yr	s. last birthda 76 yrs.	y) If Unde Months	Days		in (Month, Di	1, 1924	9. Birthp Cour PA	olaca (State or Foreign otry)
g .		Usuel Residence of	Decedent 10b. County		100 (City, Town or	Location						Od. Inside City Limits
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15-0020 72 hours after death with the Marys heaturer, or terms 23s or 28s-f sho	by Funeral	11. Marifal Sfetus 1 Never Marr 3 Widowed		Armed F	2 ☐ No ive	U,S. 13	if Yes, spe			(Specify Yes or No erto Rican, etc.)	Specify	k, White,	an Indian, etc.
Z1Z15-UUZU d within 72 hours at plens. r then 'nethref, or	Be Completed	(Spec		t grade completed,) (1-4or 5+)	(Gir	. DO NOT	ork done	during most of a	working	Nation		dustry eographic
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mil. Pages 1 and partment of Health portent: If New 27	6			3 □Removal from	Stefe	Pleca of Discametery, co	rematory or	other pla		Nov 3 2000	20c. Location - Beltsv.		
Demil. Duparti	8008	21. Signature of Fu	uneral Service L	PHO (1/		22. Name e Rapp 933	rur Fur Gist	ess of Facility neral & . Avenue	Cremation Silver	n Servic Spring,	es MD	
Chunini		23a. Pert1. Enter t shock, or hea	he diname, or our failure. List o	complications that only one cause on	caused the de each line.	eath. Do not e	inter the mo	de of dy	ing, such as card	diec or raspiratory	errest,		Approximate Interval Between Onset and Death
Physici /Medic Examin	cal	Immediate Cause disease or condition resulting in death)	(Final	Par	kinson	s Dise	ease						10 years
		resoning in deathy		Dep	Due to ression	(or as a cons	equence of	:	AL .				
cate be executed physician and the buriel reneil	edical Examiner	Sequentially list co it any, leading to cause. Enter Unde Cause (Disease or that initiated events	enditions, nmediate erlying	Б.	Due to	(or es e cons	equenca of)				11/2		100
5 01	Medical	Cause (Disease or that initiated events resulting in death)	injury s Last	c	Due to	(or as a cons	equence of)						
Seath c	iclan	Part II, Other signif	licent condition	ne contributing to	feeth but not r	aculting in the	undadvina	cours o	iven in Dert I	23h Did	I tobacco usa co	ntribute t	o the cause of death?
requires that the death cerean signed by the attendir	y Physician/R	Dement		is contributing to	Jean Dut Horn	esoning in the	underlying	cause g	ven arrecti.		Y88 2□No		bably 4 Unknown
or Attending Physician: The law requires that the death certific after death. The first or After this certificate has been signed by the attending price that the close of the control of the state of the control of t	Completed by								110	24a. Wa perf	s an eutopsy formed?	6/	ere autopsy findings vallable prior to empletion of cause death?
VICAL FREC Biclan: The law certificate has b	omi									1 🗆	Yes 20No	1	☐ Yes 2☐No
Tan:	Be C	25. Was case refer	red to medical						26. Place of I	Death (Check only	one)		
yalci is ce	TOE	examiner?	ŝNo	Hospitel:	Inpatient 2	☐ ER/Outpat	ient 3 D	OA O	ther: X 4 Nursin	g Home 5□Res	sidence 6 Oth	er (Speci	fy)
nding Ph ath. r: After th	ation:	27. Menner of Deat 1 ☐ Neturel 2 ☐ Accident	5 Pending investig	ation	of Injury nth, Day Year)	28b. Time Injury	of /	28c. Inje W 1	ury et ork?] Yes 2 □ No	28d. Describe	how injury occur	red	
or After de la Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could n determine	ned 200. Plac	a of Injury - At ting, etc. (Spe	home, farm,	street, facto	y, office		28f. Location City or To	(Street and Numb own, Stete)	er or Rur	al Route Number,
To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate ha complicate filled in by the funeral director.	edical (29e. Certifier (Check only one)	1 Certifying 2 Medicar E	xaminer: On the I	e best of my k basis of exami nner stated.	nowledge, de netion and/or	eth occurred investigation	at the f	ime, date and ple opinion, deeth o	ece, end due to the courred at the time	cause(s) and ma , date and place,	anner as s and due t	stated. o the cause(s)
To the To the	W.	29b. Signature and	fitting of contillier		1)	29	c. Licer	ise number		29d. Date signe	d (Month,	Day, Year)
3		N	V			W	1 0	000	53528		Octob	ber	30, 2000
)		30. Name and addr Daphna		who completed cau				Whe	aton, Mi	20902			
Reg	State gistrar	31. Date filed (Mon		2000	Registrar's Sig	nature \mathcal{L} .	do	ak.	iv i				

DHMH 16 Rsv 6/95



State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death

36155

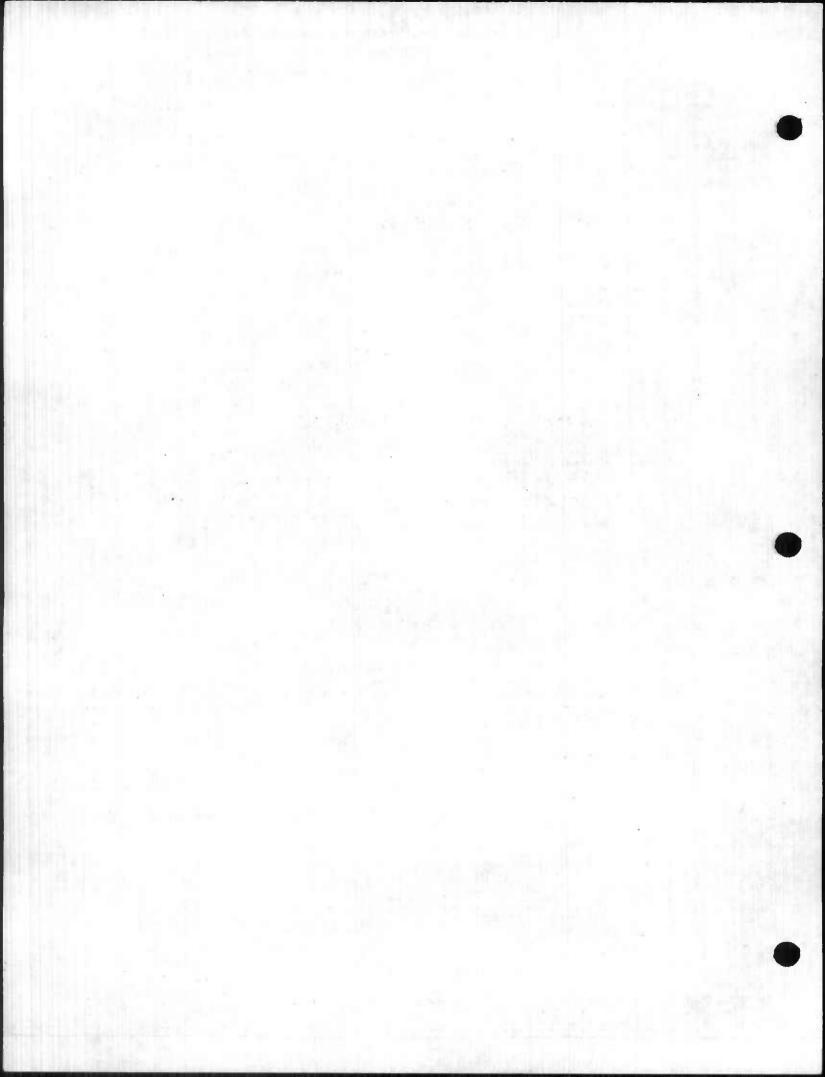
Physician	1. Decedent's Nema (First, Middle, Last) Esther			avis	Death	2. Dete of I Month OCt	Dev	000	3. Time of Death 6:25P.
/Medical Examiner	4a Facility Name (If not institution, giva: 15101 Interla		, #421			n, or Location of De er Spri		y of Deeth	ry
Funeral Director	5. Social Security Number 6. Security 141-24-2265	0.0	78 Yrs.	If Undar 1 Ye Months De		Hra. 8. Data of 8 Min. Aug • 2	9, 1922	9. Birth	pleca (Steta or Foraign ntry) and
or 28e-f show as notified at Director	Usuel Residence of Decedent 10a. Stete 10b. County Maryland Montgome		y. Town or Loc Lver Sp	ring					0d. Inside City Limits 1 ☐ Yes 25XNo
at be n	100. Street and Number 15101 Interlachen	Drive, #421		10f. Zip Code 209			10g. Citizen of Unite		
Standard 23s or 23s-1 s Examiner must be notified by Funeral Director	11. Maritel Status 1 Navar Married 2 M Merried 3 Widowed 4 Divorced	2. Wes Decedent Ever in U, Armed Forces? 1 ☐ Yea 2 ██No If Yes, Giva Yaar or Datas:		las Decedent of Yes, specify C		n? (Specify Yaa or I Puerto Rican, etc.)	No- 14. Ra Bie Speci	ce - Americ ock, White, fy: Wh	
Completed	15. Decedent's Educ (Specify only highest grade Elementery/Secondery (0-12) 12	cation completed) College (1-4or 5+)	16a. Decede (Giva k life. D		cupation ne during most (ired)	of working	16b. Kind of E	Business/In	
To Be C	17. Fathar's Name (First, Middle, Last) Louis Pelta					s Neme (First, Midd Stern	le, Maiden Suma	me)	
r traumatic	19e. Informent's Name/Raiationship (Type Sidney Davis (hush			Address (Stre		or Rural Route Nun	nber, City or Town	n, Stete, Zip	Code)
reportant: If hen 27 is marked other try injury or other traumatic event, 1 anse. To Be Co	20e. Method of Disposition 1 Burial 2 Cramation 3 R 4 Donetion 5 Other (Specify)	C	lace of Disposemetery, cremited Me	atory or other i	Gardens	Dete 10/31/0	20c. Location		
Important any injury ansa.	21. Signeture of Earland Service Louise	Land 1				ardt Fune			1and 20705
nding physician and Medical Examiner	23a Fant. Entered disease, or compliance, or hear fellure. List only or limited and control or limited and control or established	Due to (or PARKINSS	r as e consequ ASCUL r es e consequ	nence of): AVZ 1 nence of): ISCASE	DISEAS E				trifervel Between Onset and Death 2 Wllks
nis certificate has been signed by the attending I director, page 2 should be deteched for use a. To Be Completed by Physician/Me	Pert It. Other eignificant conditions con MULTI - IN FARCET			derlying cause	given in Part I.	1	d tobacco use c	3 Pro	o the cause of death? bebly 4 Unknow
e has been age 2 shoul omplete				14		pe	rformed?	of of	vailable prior to ompletion of causa death?
To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be deteched for unpletely filled in by the funeral director, page 2 should be deteched for unpleted by Physician	27. Menner of Death 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be	28a. Dete of Injury (Month, Day Year) 28e. Piece of Injury - At ho	ER/Outpatient 28b. Time of Injury	28c. li	Other: 4 Num njury at Vork? Yas 2 N	of Death (Check on sing Home 5 28d. Descrit	y one) sidence 6 One how injury occurrence of Num	thar (Speci	(y)
hours afte meral blin by filled in cal Cert	29e. Certifier Certifying Phys	building, etc. (Specify	wledge, death	occurred at the	time, dete and	place, and due to ti	Town, Stete) ne cause(s) and n	nanner as	stated.
To the Fu completed	29b. Signeture end title of certifier	mpleted cause of death (Item		29c. Lic	ansa number		29d. Date sign	ed (Month,	Day, Year)
	30. Name end address of person who co Haward D. (HA?	mpleted cause of death (trem	23a) (Type, P	condword	1 CT #	201 0/11	y MD	201	932

State Registrar

31. Dete filed (Month, Day, Year) OCT 31 2000

Harrard D. (HAZIN 32 Registrar's Signeture

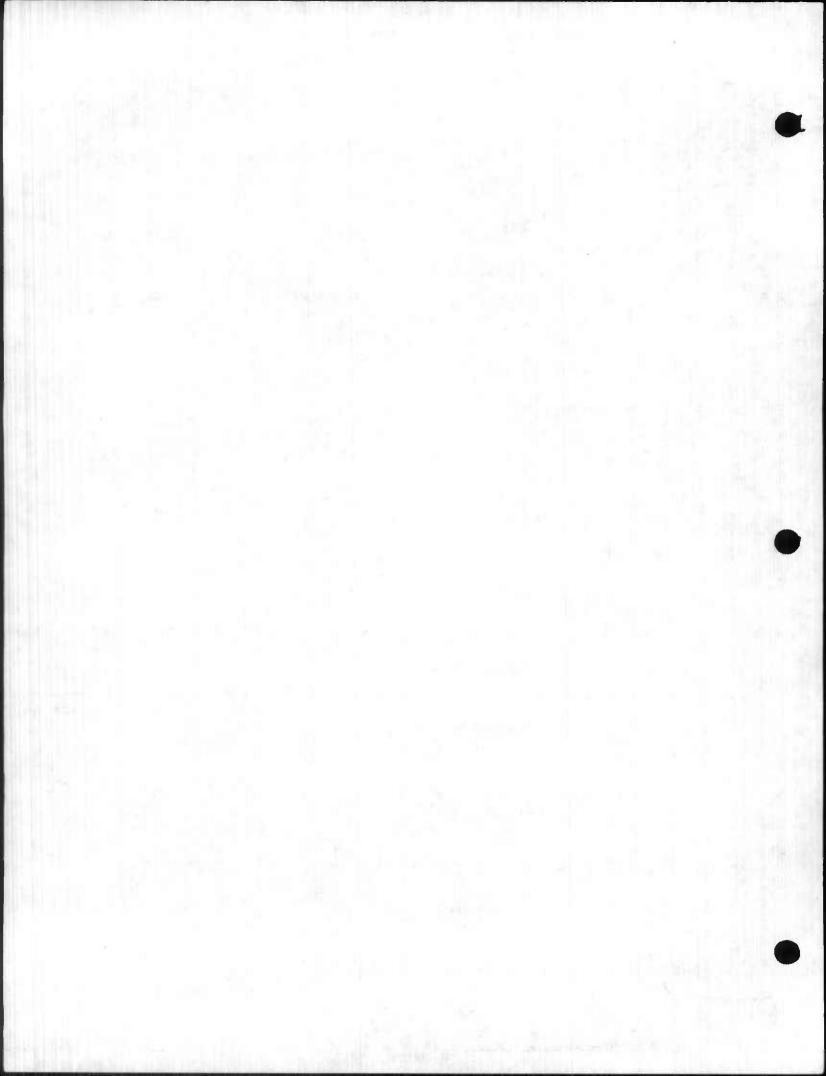
souls



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

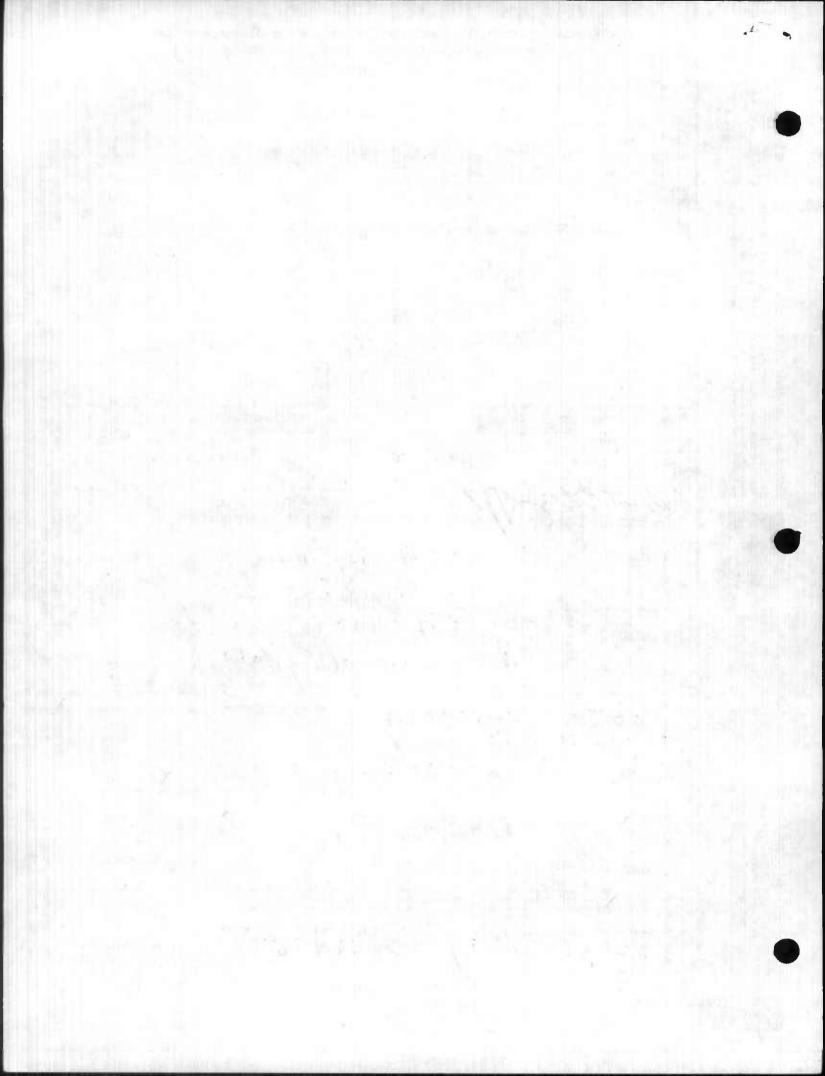
State of Maryland / Department of Health and Mental Hygiene 36 | 56

hysician /Medical					001	imou	10 01	Death			Reg. No.		
	1. Decedent's Name (First, Middle	e, Last)								2. Dete of De Month	Dev	Year	3. Tima of Death
	Hazel Dixon									October	18, 20	00	7:30 P.M
xaminer	4e Facility Name (If not institution					260				cation of Deatl	4c. County of	of Death	E. BU6
	Frederick Me	morial	Hosp:	ital				Frede			Frede		
neral	5. Social Security Number	6. Sex			last birthday) Yrs.	Months	Days		Min.	8. Dete of Bir (Month, Da	th y, Year)	9. Birtho	place (State or Foreign
ector	220-10-1607		X.	85	115.					Feb. 2	6, 1915	West	t Virginia
	Usuel Residence of Decedent 10a. State 10b. County			10c. City	y, Town or Lo	cation					7.00	1	IOd. Inside City Limits
Director	Maryland Frede	erick		Fre	derick								1 ☐ Yes 2 ☐ No
Directo	10e. Street and Number			1		10f. Z	ip Code				10g. Citizen of W	hat Cour	ntry?
0	2880 Basford	Road					1702				U.S.A.		
96.	11. Marital Status	12. Wa	s Decedent	Ever in U,	S. 13. V	Ves Dec	edent of H	lispanic Origin	n? (Spe	city Yes or No Rican, etc.)	- 14. Race		can Indian,
F	1 Never Married 2 Marr		ned Forces? Yes 2 7			_	_		Puerto I	rican, etc.)		c, White,	
by	3 ₩ Widowed 4 Divorced	Ye	es, Give 11 ar or Dates:			ILI Yes	2₹ No	Specify:			Specify	White	2
eted	15. Decedent	it's Education	leted)		16a. Deced	kind of w	onk done	during most a	of working	na	16b. Kind of Bu	siness/In	dustry
Compl	Elementery/Secondary (0-12)	1	llege (1-4or	5+)			use retire	d)					
8	8	4 = -41		11/1	Hom	emak	er	40 14-41-4	. No.	Cinc. Middle	Own I		
Be	17. Father's Name (First, Middle, Silas	Last)			Smith				CV CV	(FITS), Middle,		bb	
5							10:		,	10			0.41
	19a. Informant's Name/Relations Mrs. Carolyn Wh			hter							er, City or Town, S Ville, N		
	20a. Method of Disposition	, correr	2446	20h D	less of Dispo	cition (A)	ama of		1	Data	20c. Location - 0		
	1 Buriel 2 Cremation		I from State	Mo	emetery cren	natory or	other pla	y, Oct.	20.	2000	Frederic		
	4 □ Donation 5 □ Other (Si								1				
900	21. Signeture of Purietal Service	2 H	1	M002							Funeral		
	1 Juchano	(12 - 2	The same		1						erick, M	1d. 2	
	23a. Pert1. Enter the disease, or shock, or heart failure. List	only one caus	se on bach I	ine.	n. Do not enti	er the mo	oe or ayır	ng, such as ca	ardiac o	respiratory a	rrest,		Approximate intervel Between Onset and Deeth
in ai	Immediate Cause (Final												
	disease or condition resulting in death)	a C	18per	ann	r as a conseq	un	ron	u.					16 days
e e				Due to (o	rasa conseq	uenca of): 	. A:				i	0
Examiner	Constant the first constitution	b g	jasor	Dua 10 10	r es a conseo	U O	3086	Wy	, ,			1	
Exa	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that inflated expenses		,	Due 10 (0	os a conseq	Delica of	·	note.		and.	040	1	
cai	I fligt allitiated gaelitz	c. 1	rype	Due to (or	es a consequ	uence of	in	Cero Co	7	yndi	1 1000		
2	resulting in death) Last		34			10.	6	h. Sie t	50	ene,		i	
M/VIE		d	ucc	Unu	ma,	rra	100	012 16				1	
sicia	Part II. Other eignificant condition	ons contributir	g to death t	out not resu	ulting In the ur	nderlying	cause giv	ven in Part i.		23b. Did	tobacco use con	tribute t	o the cause of death'
Physician										10	Yee 2 No	3 Pro	bably 40 thknow
by				-									
Completed											an autopsy ormed?	a۱	fere autopsy findings
pje									_				ompletion of cause death?
Con										1 🗆	Yes 2 DNo	1	Yes 2010
Be	25. Was case referred to medical axaminer?	-					100		of Death	(Check only	one)	1 11	
2	1 Yes 20 No	Hospita	Uempati	1	ER/Outpatien		JOA				denca 6 □Othe		(y)
	27. Menner of Beath 1 Natural 5 Pendin	ng	Month, De		28b. Time of Injury		28c. Inju Wo			28d. Describe	how injury occurr	ea	
lon:	Investig	gation not be	51			M		Yes 2 No		of Location	Street and Number	or or Pur	rel Poute Number
cation:	2 Accident		building, e	ic. (Specify	ome, farm, atr	eet, facto	лу, опісе			City or To		er or nur	ar noble Number,
ertification:	3 Suicide 6 Could a 4 Homicide	iiiiou					3						
i Certification:	3 Suicide 6 Could a determ		To the best	of my lines	ula dan dan d		d as the si			and due to the	anuna(a) and ma		stated
dical Certification:	3 Suicide 6 Could r determ 3 Suicide 4 Homloide Certifyin (Check only 2 Medical	ng Physician: Examiner: Or	the basis o	f examinal							cause(s) and ma date and plece, a		
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edicai	3 Suicide 6 Could redeterm 3 Suicide 6 Could redeterm 29a. Certifier (Check only one) 2 Medical cone) 29b. Signature end title of certifier	ng Phyeician: Examiner: Or an	the basis of d manner st	f examinal ated.	tion and/or Inv	vestigation 2	on, In my o	opinion, death	occurre	ed at the time,	date and plece, a	ind due t	Day, Year)
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pletely fill edical	3 Suicide 6 Could redeem 4 Homicide 29a. Certifier (Check only one) 1 Certifyin 2 Medical	ng Phyeician: Examiner: Or an	the basis of d manner st	f examinal ated.	tion and/or Inv	vestigation 2	on, In my o	opinion, death	occurre	ed at the time,	date and plece, a	Ind due to	Day, Year)



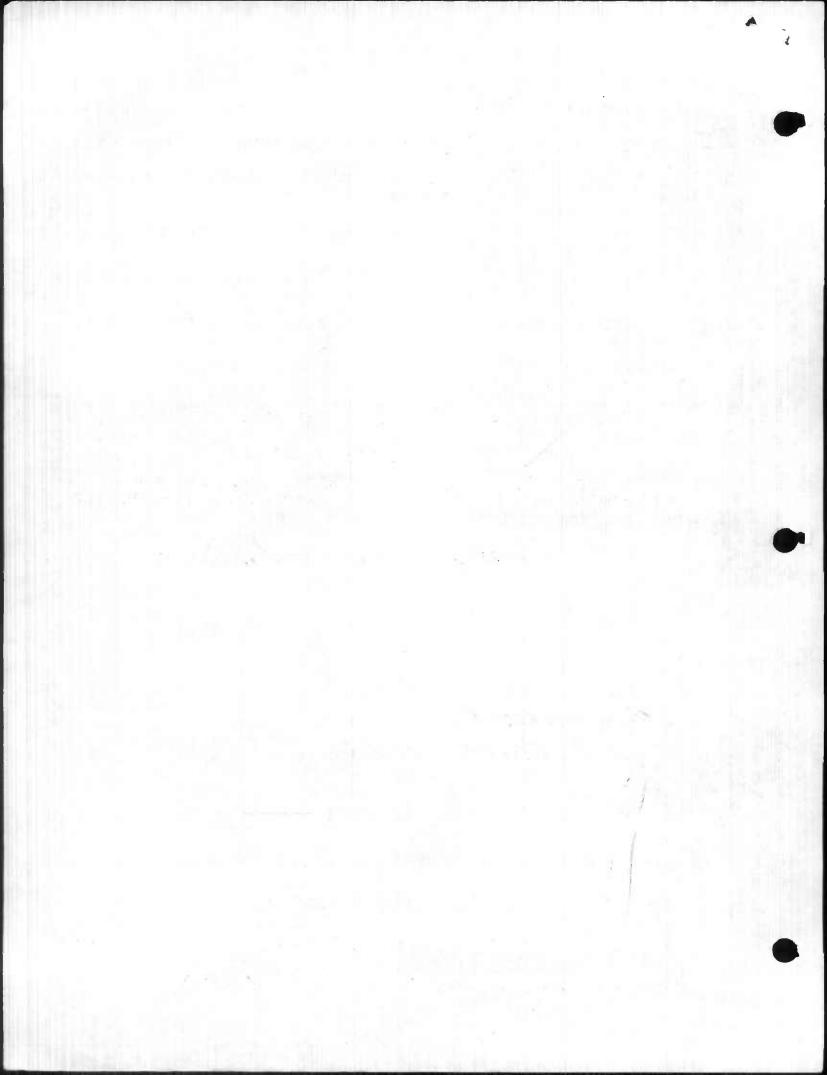
State of Maryland / Department of Health and Mental Hygiene 00 36/57

					Certifica	ite of	Death			Reg. No.		
	Physician	1. Decedent's Name (First, Midd		rl DeLau	ter				2. Date of Dea Month Octobe	ith Day	OOO	3. Time of Death
	/Medical Examiner	4a Facility Neme (If not institution 15965 Manahan	The second secon	per)			4b. City, To Sabil		ocation of Death		y of Death lerick	c
	° Funeral Director	5. Social Security Number 217–28–1032	6. Sex 7. 1 M 2 F	Age (In yrs. last b	Yrs. If Unc Month	ler 1 Year s Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day Jan. 1	1928	9. Birthp Court Mary	place (Stete or Foreign nto) Land
	and and	Usual Residence of Decedent 10a. State 10b. Count	у	10c. City, Tox	wn or Location						1	Od. Inside City Limits
	after death with the Meryland or Name 23e or 28e-f show mine must be notified at Funeral Director	Maryland Fred	erick	Sab	illasvi	Lle				10g. Citizen of	Martines Cours	1 Tyes 2 No
	ifter death with the Me r fleme 23a or 28=f s increment be modified Funeral Director	15965 Manahan				217				U.S.A		
020	urs after al', or its by Fur	3 ☐ Widowed 4 ☐ Divorce	If Yas, Give	es? A No	if Yes, sp	pecify Cub	an, Mexicar	gin? (Sp n, Puerto	ecify Yas or No- Rican, etc.)		ce - Americ ick, White, by: Wh	
21215-0020	5 . c = 0	15. Decede (Specify only high: Elementary/Şecondary (0-12)	nt's Education est grade completed) College (1-4)		Give kind of a	vork done use retire	during mos	t of work	ing	16b. Kind of B		dustry
		11			Fa	armer	-				ming	
Maryiand	Sa Sa Sa	17. Father's Name (First, Middle George W. DeLa					Marc		e (First, Middle, ray	Meiden Sumer	ne)	
	d 2 sho th and 7 is ma traum	19e. Informant'a Name/Relation Pauline DeLaut		19	b. Meiling Addre 5965 Mai	ss (Stree nahan	r end Number Road	, Sa	al Route Number billasv	ir, City or Town	, State, Zip D 217	780
Baitimore,	of Herr f Herr r oth	20a. Method of Disposition 1 Durlal 2 Cremation 4 Donetion 5 Other (cemete	of Disposition (A ery, cremetory o r Cemeto	r other ple	oce)	1	Date 0/16/00	20c. Location Thurmo		own, State Maryland
Bait	permit. Pag Department Important: I any injury o	21. Signature of Euperal Septe	La Ozef	6					SON FUN			
	Physician /Medical Examiner Examiner	Immediate Cause (Final disease or condition resulting in death)	a Car	diac Due to (or as mary	consequence of	hy:	thn	169	C S D	rest,		Approximete Interval Between Onset and Deeth Minutes Years
Box 68760,	ficate be g physicia as the bu	Cause (Disease or injury that initiated events resulting in death) Last	Chi	TRUE E	f Dr consequence o	ral	Fa	ile	nelli	7265	6	fears Month
s, P.O.	the sch	Part II. Other significant condit	c Nec	th but not resulting	in the underlying	cause g	ven in Part i	i.		obacco use co Yes 2 No		o the cause of death?
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/ita	entific ector.	25. Was casa referred to medic exeminer?					COLUMN TO THE REAL PROPERTY.	e of Dea	th (Check only o	ne)		
of	Physicien: r this certific ral director,	1 Yes 2 No	Hospitel: 1 🗆 Ing		Outpatient 3	DUA		ursing Ho	ome 5 Resid			(y)
Division of Vitai	after death. Director: After d in by the funer ertification:	2 Driccident	tigation	Dey Year)	Time of Injury M	28c. Inju Wo 1	ork? Yes 2	No	28d. Describe I	now injury occu	rred	
	us or Attending P rs after death. al Director: After t led in by the funers Certification:	3 Suicide 6 Could deten	mined 209, Placa 0	f Injury - At home, t , etc. (Specify)	farm, street, fact	ory, offica			28f. Location (S City or Tox		ber or Rura	al Route Number,
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completaly filled in by the funeral director, page 2 Medical Certification: To Be Comp	29a. Certifier (Check only one) Certify	ing Physician: To the bit Examiner: On the bas and manne	is of examination a	ge, death occurre ind/or investigati	ed at the t	ime, date an opinion, dea	nd place, ith occur	and dua to the red at the time,	cause(s) and m date and placa,	anner as s , and due l	stated. o the cause(s)
	Toth comp	29b. Signeture end title of certifi	ecill	lay ,	20	9c. Licen	se number	63	SL.	29d. Date sign	d (Month,	Dey, Year)
		George E. Way,	MD 324 Ea	st Antie		eet,	Hager	stov	m, Mary	land 21	740	•
	State	31. Date filed (Month, Day Year	9 0 2000 32. Reg	istrar's Signature								



DHMH 16 Ray 6/95

Registrar



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Health

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Important: If item 27 any injury or other to

Physician /Medical

Examiner

physician and s the burial-transit

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certificate

After this

after death.

within 24 hours aft To the Funeral Di completely filled in Hospital

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n of Vitai Records, P.O. Box 68760,	or Attending Physician: The law requires that the death certificate be executed
S. Box	e death cer
ds, P.C	ires that the
Recor	e law requ
Vitai	reician: Th
sion of	anding Phy
Division	or Att

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month **Physician** Cornelius H. Daly OCTOBER 24, 2000 3:35 AM /Medical 4a Facility Neme (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** VA MARYLAND HEALTH CARE SYSTEM PERRY POINT CECIL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 10 M 20 F Yrs 158-24-2049 69 Director Mar. 17, 1931 New Jersey Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No New Jersey Cumberland Millville 10e. Sfreef and Number 10f. Zio Code 10g. Citizen of What Country? 08332 200 Evergreen Road USA Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 12 Yes 2 □ No If Yes, Giva 11. Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian. Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 Ø No Specify: Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Carpenter Construction 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First Middle Maiden Sumeme) Be Cornelius J. Daly To Gertrude Creamer 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) James Daly/Son 303 North Twelfth Street Millville, NJ 08332 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Laurel Lawn Crematory 10-28-00 Bridgeton, New Jersey 21. Signature of Fuderal Service Licen 22. Nama and Addrass of Facility R. T. Foard Funeral Home, P. A.

111 S. Queen St., Rising Sun, MD 21911

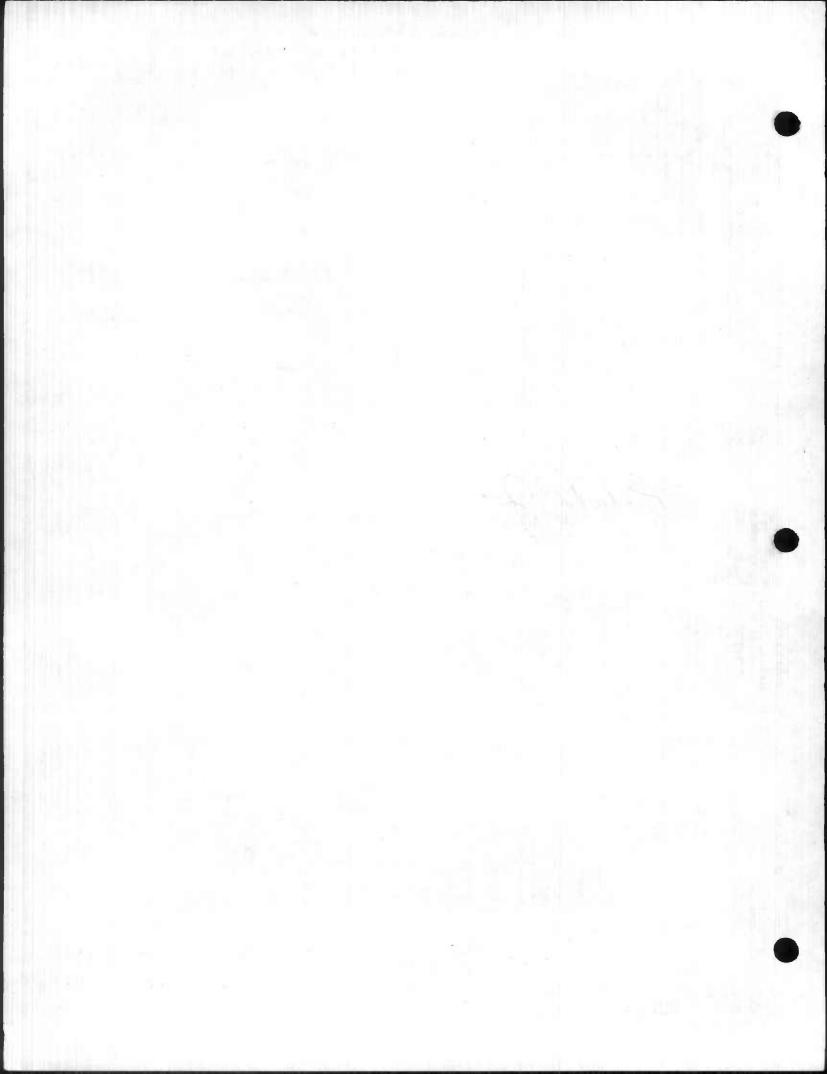
Show, or heer failure. List only one cause on each type. Approximate Interval Between Onset and Deeth Immediate Cause (Final CHRONIC MYELOCYTIC MONOCYTIC LUEKEMIA disaese or condition resulting in death) UNKNOWN Due to (or as a consequence of) Examiner BILATERAL CAROTID ARTERY DISEASE UNKNOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 11 Yas 2 No 3 Probably 4 Unknown PY 24b. Were autopsy findings available prior to completion of causa of death? 24e. Was en eutopsy performed? Completed 1 Yas 2K No 1 Tyes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 45 Nursing Homa 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 1 fnpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Metural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of fnjury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and mannar as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29c. License number 29b. Signatura and fitle of certifier 29d. Data signed (Month, Day, Year) D20215 OCTOBER 24, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KARMACHANDRA NAIR, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MARYLAND 21902 OCT 2 5 2000 32. Registrar's Signeture State Registrar Sparks

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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nysician Medical	1. Decedent's Name (S	eV-1					2. Date of Dea Month 10	Day	Year	3. Time of Death 3:08 Am
aminer	4a Facility Name (If no Holy Cros	ss Hospi	tal					Silve	r Sp		Mont	gomer	-
ral tor	5. Social Security Nur NONE Usual Residence of D	1	ex □M 25√F	7. Age (In yrs.	last birthday) Yrs.	If Under Months	Days	Hours 5	24 Hrs. 24	8. Dete of Birth (Month, Day OCt • 2	0, 2000	9. Birthp Coun Mar	lace (State or Foreign try) 191and
otor	10a. State	Ob. County Prince	George'		ty. Town or Lo							1	0d. Inside City Limits 1 ☐ Yes 2 No
al Directo	10e. Street and Numb		nue			10f. Zip	Code 2070	5			10g. Citizen of V Unit		tates
by Funeral	11. Marital Status 1X Never Married 3 Widowed 4		12. Wes Dece Armed Fo 1 Tes If Yes, Giv Year or De	2 X No		Wes Deced If Yes, spec		ispanic Ori in, Mexican Specify:	gin? (Spe , Puerto	ocify Yes or No- Rican, etc.)	14. Rec Blac Specify	e - Americ k, White, Wh	
Parallel Inco	(Specify	5. Decedent's Education only highest graduary (0-12)	ucation de completed) College (1	-4or 5+)	(Give	dent's Usue kind of wor DO NOT us	k done d	during most	of worki	ng	16b. Kind of Bu	siness/Inc	dustry
ŀ	17. Father's Name (Fi	irst, Middle, Last)			nor	e		18. Mothe	r's Neme	(First, Middle,	none Maiden Sumam	e)	
		Gerald	Elkins					Ang	_		bczak		
10	19a. Informant's Nam					_			er or Rura	I Route Numbe	r, City or Town,	Stete, Zip	Code)
-	Angie Kay 20a. Method of Dispos		(motne	20b. l	Sa Place of Disponentery, cre	me as	ne of		1	Dete	20c. Location -	City or To	wn, Stete
Physician/Medical Examiner	23a. Part I. Enter the shock, or heart I Immediate Cause (Fin disease or condition resulting in death) Sequentially list cond if any, leading to immeause. Enter Underly Cause (Disease or in that indiated events resulting in death) Last Part II. Other significations of the condition of the cond	itions, ediate ing ury st	a. PU b. 0 c. U d. ontributing to de	Due to (c) Due to (c) Due to (c)	y hy for es a consecutive a consecutive in the u	quence of): Amniquence of): abniquence of):	OS TYM	ality en in Pert I	,		obacco use co	ntribute to	Onset and Deeth
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Completed											es 2 No	10	Yes 20 No
	25. Was case referred examiner? 1 Yes 2 No		Hospital:	npatient 2	ER/Outpatie	nt 3[] DO	A Oth	ar _		n <i>(Check only o</i>	re) lence 6 🗆 Oth	er (Specif	v)
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Certification:	3 Suicide 4 Homicide	6 Could not be determined	288. Place	of Injury - At h ng, etc. (Speci		reet, lectory	, office			28f. Location (S City or Tow	itreet and Numb n, Stete)	er or Rura	t Route Number,
edicai		Certifying Ph		isis of examine									
M	29b. Signature and rit	le of certifier	m			100		4008	>	1	29d. Data signe	1	Day, Year)
tate	30. Name and address Catherine 31. Date filed (Month,	Gannon	M.D.	e of death (Iter L500 Fo	rest G	Print) len R	d. S	Silver	Spi	ing, Ma	aryland	2091	0

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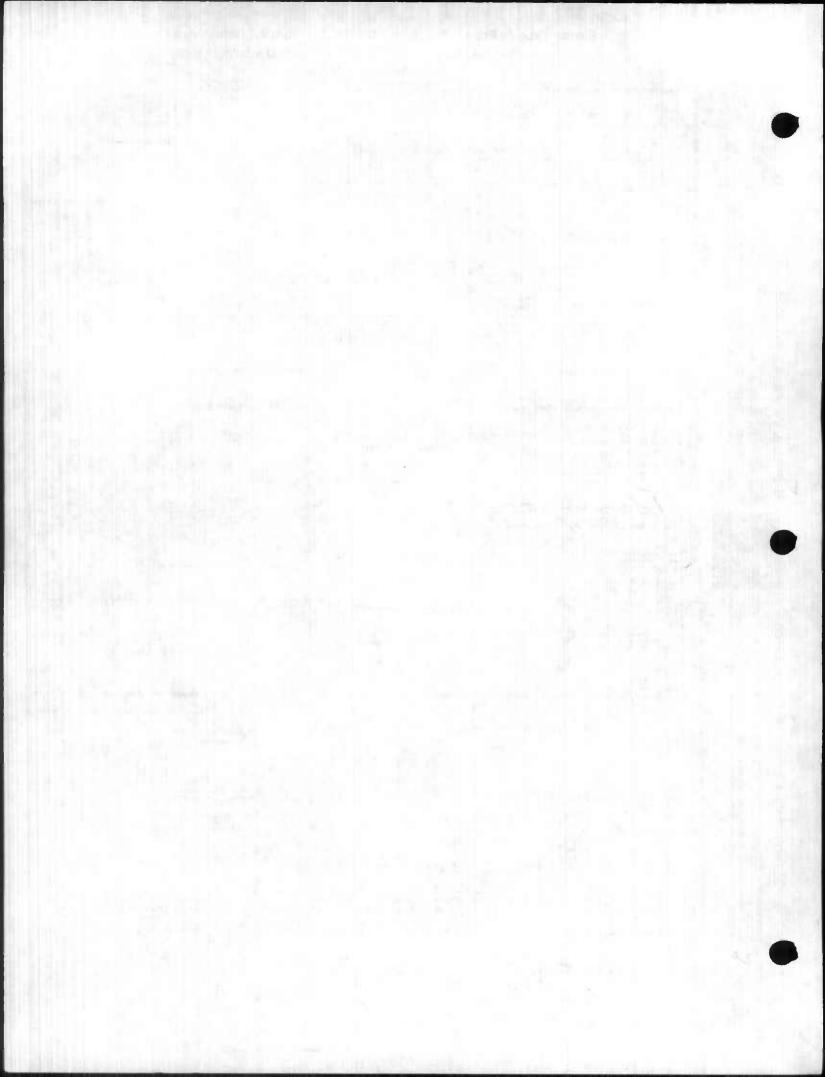
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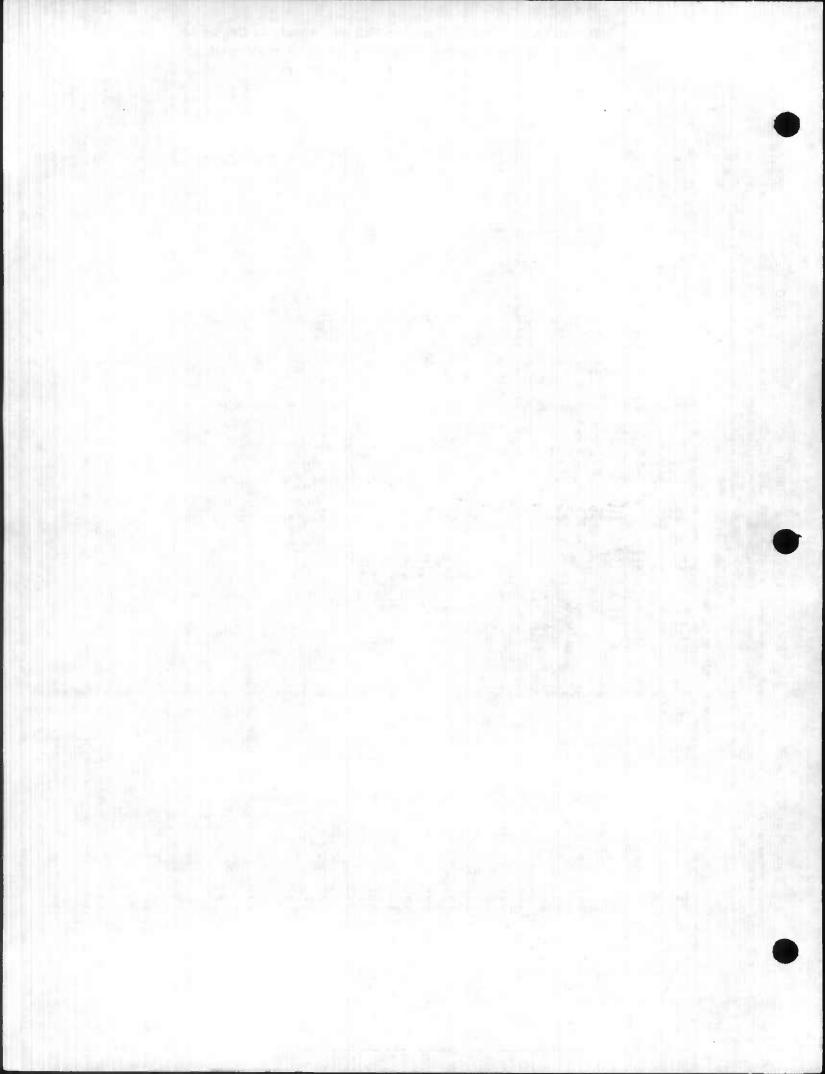
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	082-28-2795 Usual Residence of Decedent		65	113.			Aug. 1	9, 1935	New Y	ork
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	MD Monts	zomery	Pot	omac						1 ☐ Yas 2 ☑ No
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Aller and the second	9313 Falls Brid	ige Lane		Time I	20854			U.S.A.		
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	Maurice M. 19e. Informant's Neme/Reletionsi	Davis		IOh Mailing Ad	drace (Stragt			ber, City or Town	State Zin C	(ode)
	Edward L. France					idge La		tomac,		
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		500	00,				ONS, INC			2224
	230 Part 1 Enter the disease or	complications that cause	the death [5130	Wiscon	nsin Ave	e., NW	Washingt		
	23a. Pert1. Enter the diseese, or shock, or heart feilure. List	only one cause on each li	ne.	SO FIOT OFFICE THE	mode or dyn	g, sacir os cara	ac or respiretory	0,1001,	Ir	opproximete Intervel Between Onset end Death
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State of Maryland / Department of Health and Mental Hygiene 00 26162

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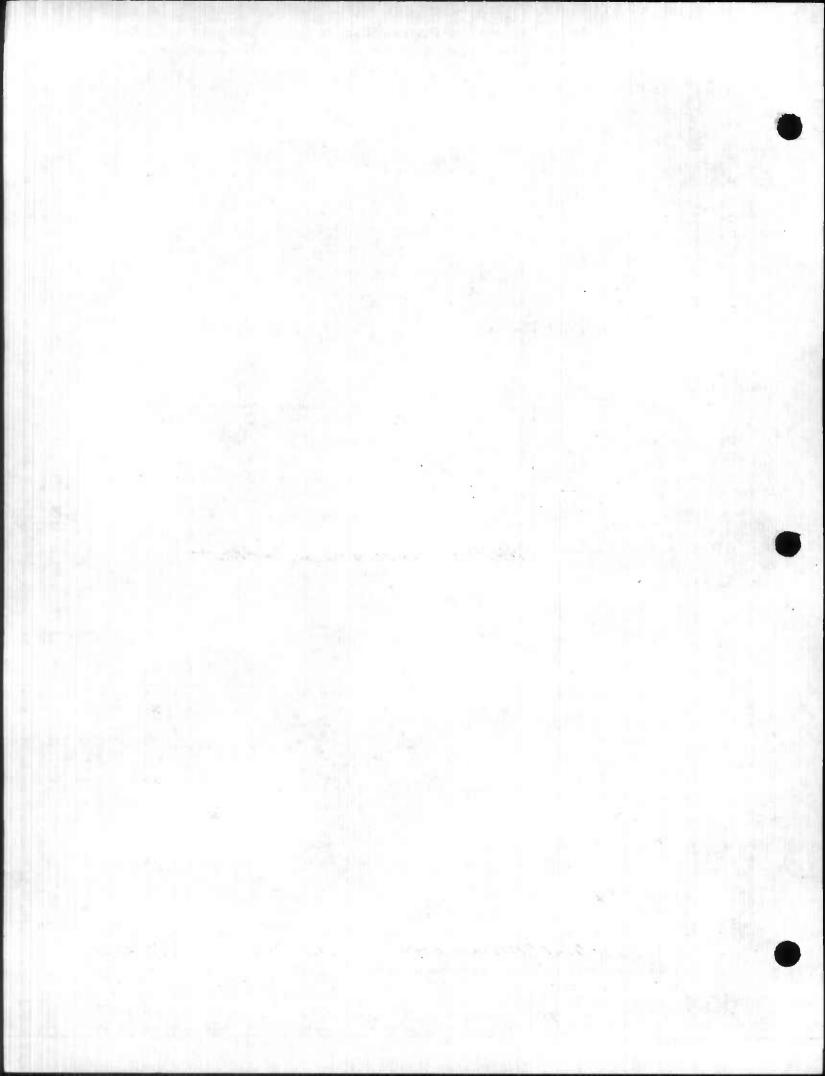


State of Maryland / Department of Health and Mental Hygiene 1 3 5 1 6 3

				Certific	ate of	Death	R	eg. No.	00100	
	Decedent's Neme (First, Middle, Las	it)					2. Date of Dear		3. Time of Death	-
/ivieutcar	Sharon E. Fel						October	28, 200		
Cxammer	Facility Neme (If not institution, give						r Location of Death	4c. County of		
E C	3713 Mount Olney Sociel Security Number 6. Se		(In yrs. last bin	thday) If Ut	nder 1 Yeer	Olney	s. 8. Date of Birth		omery	-
ector 0		□M 2□XF 58		Yrs. Mont				Year) 8, 1942	9. Birthplece (State or Foreign Country) NEW YORK	
10a	a. State 10b. County MD MONTGO	MERY	10c. City, Town	n or Location		- C			10d. Inside City Limits 1 ☐ Yes 2 ☐Ño	
10e 3	e. Street and Number	LANE		10f.	Zip Code	2	1	0g. Citizen of Wh	nat Country?	
D	Marital Stetus 1 ☐ Never Merried 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Yeer or Dates:		1-1-1-11		Hispanic Origin? ban, Mexicen, Pue Specify:	Specify Yes or No- into Rican, etc.)		- American Indian, White, etc. White	
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	12 Father's Name (First, Middle, Last)	4		Teacl	ner	18 Mother's N	eme (First, Middle, I	Educa Maiden Sumeme		-
m	George E. Nyman						H. Reaga			
-	e. Interment's Neme/Reletionship (7	ype, Print)	19b	. Meiting Add	ress (Stree		Rural Route Number		itate, Zip Code)	-
M	Michael Fellin /	Husband	37	13 Mou	nt 01	ney Lane	, Olney,	Marylan	d 20832	
20a	a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify		20b. Plece of cemeter						ity or Town, State pring, Maryland	d
21.	Signature of Funeral Service Licen		10	22. Nam	e end Addr	ess of Facility[]	1	DI 11800	NEW HAMPSHIRE	-1
er dis	mediete Cause (Final sease or condition sulting in death)	b	Due to (or as a o	consequence	ot):	oma of	Breast			1
Car tha res	equentially list conditiona, iny, leeding to immediate use. Enter Underlying use (Disease or injury at initiated eventa sulting th death) Last	c	Due to (or as a c	consequence	ot):					
Physician	rt II. Other algnificant conditions co	ontributing to death bu	it not resulting in	the underlyi	ng cause g	iven in Part I.	23b. Did to	obacco usa cont	ribute to the cause of death?	
by Phy							1 D Y	as 25 No	3 Probably 4 Unknown	
Completed							24e. Was a perfor		24b. Were autopsy findings aveileble prior to completion of cause of death?	
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m	. Was case referred to medical examiner?	Hospital:			0	hor	eath (Check only or			_
27.	1 ☐ Yes 25 No Menner of Death	1 ☐ Inpatie		tpetient 3	TOON	4 El Muising	Home 5 Resid	ence 6 Other		
ation	1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	(Month, Dey	Year) I	njury M		Yes 2□No		treet end Numbe	r or Rural Route Number,	
	a. Certifier 1 Certifying Ph	rsician: To the best o	t my knowledge examination en				ce, and due to the c	ause(s) and man	ner as stated. nd due to the cause(s)	
29 t	b. Signature and title of certifier	and menner sta	led.		29c. Licen	se number	1 2	9d. Date signed	(Month, Day, Year)	-
	· Robert	Suane				25 D.C		10/3.		
	Nome and address of person who o				oad	N.W. Wa	shington.	DC 200	007	
	Dete tiled (Month, Day, Year)		r's Signeture		,					

DHMH 16 Ray 6/95

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) **Physician** Carol Robert Freed October 15, 2000 6:50 AM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5708 Shookstown Road Frederick Frederick 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dev. Year) **Funeral** Days Hours Yrs. Director 217-18-7805 Jan. 8, 1925 Maryland Uauai Residence of Decedent 10a. State 10c. City, Town or Location 10d. fnside City Limits 10b. County 1 Yes 2 No **Funeral Director** Maryland Frederick Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5708 Shookstown Road 21702 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 M Yes 2 D No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Merital Stetus 1 ☐ Never Merried 2 ☑ Merried Specify: 1 ☐ Yes 2 No Specify: p 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 Management Analyst Federal Government Dearment. Pages 1 and 2 should be file. Department of Health and Mental Hermontant: if item 27 is meritany or other. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) George Franklin Freed Ellen Elizabeth Myers 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Freed, wife 5708 Shookstown Road, Frederick, MD 21702 20a. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 10/18 1 XBurial 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 2000 Mt. Olivet Cemetery Frederick, Maryland 21. Signature of Funeral Service USensee 22. Name end Address of Facility Keeney and Basford Funeral Home 23e. Pert1. En le the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or learn failure. List only one cause on each line. 106 East Church Street, Frederick, MD Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical 600 m = 6-0156-45-9 Examiner Due to (or as a consequence of) Physician/Medical Examiner m 0 0100 CALCITOO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thef initieted events resulting in death) Lasf Due to (or as e consequenca of): Due to (or as e consequence of): Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown p 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed 2 NO 1 ☐ Yes 2 ☐ No 1 ☐ Yea Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 27. Menner of Death 28b. Time of 28d. Describe how Injury occurred

The law requires that the death certificate be execut and Box 68760, ed by the attending physician detached for use as the buna P.O. I After this certificate has been signed by funeral director, page 2 should be detac Division of Vital Records. Physician; Certification: epital or Attending Prious after deeth. within 24 hours a To the Funeral D completely filled

with the Maryland

death

filed within 72 hours after

Baltimore, Maryland 21215-0020

"natural", or items 23s or 28s-f show

other treumstic event, the Madical Examiner must be notified at

then

28c. Injury at Work? 1 Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

29a. Certifier

Medical

Descritiving Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinerination and/or investigation, in my opinion, deeth occurred at the time, date and pleca, and due to the cause(a) and manner stated.

29b. Signeture end title of certifier

29c. License number

29d. Date signed (Month, Dey, Year)

D146 2C

006 16,2000

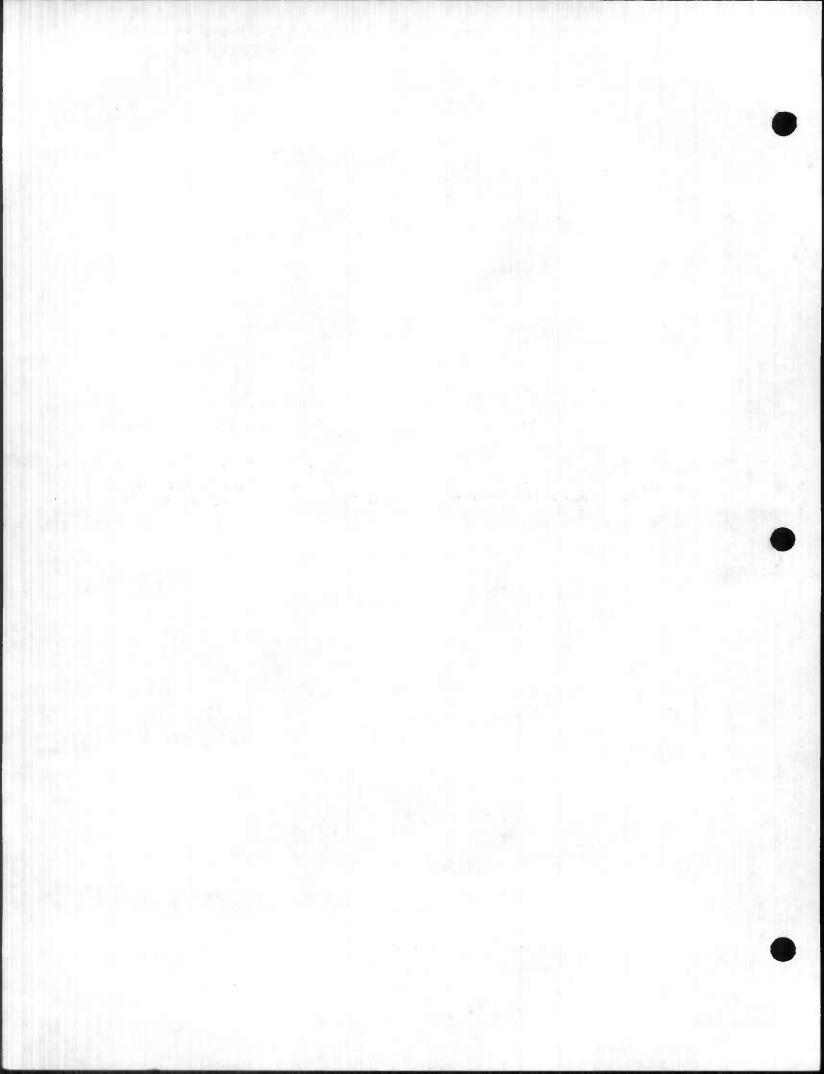
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200366

32. Registrar's Signature

State Registrar

State of Maryland / Department of Health and Mental Hygiene 0 36

	Decedent's Name (First, Middle, Last)		Certificate		2. Dete of Death		3. Time of Death						
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eral	5. Sociel Security Number 6. Sex		last birthday) If Under 1 Y	ear If Under 24 Hrs.			Birthplace (State or Forei Country)						
ctor	213-40-8038	M 2⊠F 96	Yrs. Months D	ays Hours Min.	Sept. 1,		aryland						
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tor tor	Maryland Montgome	rv	Gaithersburg				1 💢 Yes 2 🗆 N						
irecto	10e. Street and Number		10f. Zip Co		10	g. Citizen of What	Country?						
E D	212 South Frederi	ck Avenue		20877		U.	S.A.						
Funeral	11. Meritel Stetus	2. Wes Decedent Ever in U Armed Forces?	S. 13. Was Decedent	of Hispanic Origin? (Sp Cuban, Mexican, Puert	pecify Yes or No-		merican Indien,						
20	1 Never Merried 2 Married	1 ☐ Yes 2 No			o rucan, etc.)	Bleck, W	nite, etc.						
by	3⊠ Widowed 4 □ Divorced	If Yes, Give Yeer or Detes:	1∟ Yes ZY	No Specify:		Specify:	Thite						
scal	15. Decedent's Educ (Specify only highest grade	eation	16a. Decedent's Usual O	ccupation	kina 10	8b. Kind of Busine	ss/Industry						
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Be	17. Father's Neme (First, Middle, Last)			18. Mother's Nen	ne (First, Middle, Mi	aiden Sumame)							
To	George M. Keph		E1:										
Taum.	19e. Informant's Name/Reletionship (Typ.		19b. Melling Addrass (S										
20	Diane F. Adams -		212 South F	rederick Av	venue, Ga	ithersbu	rg, Marylan						
200	20e. Mathod of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Re		Place of Disposition (Name of cemetery, cremetory or other	r plece)	Date 20	Oc. Location - City	or Town, Stete						
4	4 Donation 5 Other (Specify)	Fo	rest Oak Ceme	etery 1	0/21/2000	Gaither	sburg, Mary						
N III	22 Name and Address of Facility												
5 8	Olin L. Molesworth P.A., Funeral Home												
	23e. Pert1. Enter the disease, or complice shock, or heart failure. List only on	cetions that caused the deet	h. Do not enter tha mode of	dying, such es cardiac	or respiretory arres	st.	Approximete						
ian	shock, or heart failure. List only on	e ceuse on each line.					Intervel Between Onset end Deeth						
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ner	disease or condition resulting in deeth)		Infarction or es e consequence of):				Minutes						
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page 2 should	25. Wes casa raferred to medical examiner?	ospital:		Other	1 ☐ Yes)	of death?						
ar director, page z snould To Be Completed	examiner?	1 □ Inpatient 2 □	ER/Outpatient 3 DOA 28b. Time of 28c.	Other: 4 Nursing H	1 ☐ Yes) ace 6 Other (S	of death?						
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State of Maryland / Department of Health and Mental Hygiene 36 | 66

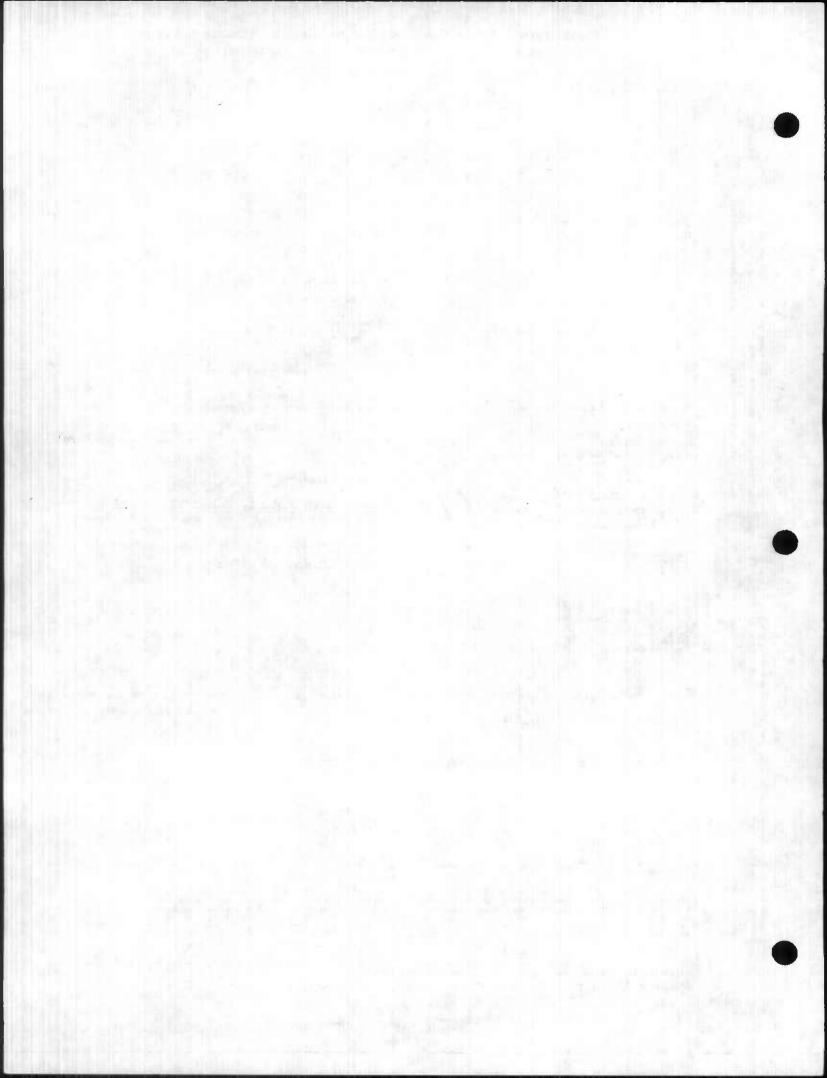
Certificate of Death

Reg. No.

			Ce	ertificate of	Death	F	Reg. No.		0100
Physician	Decedent's Name (First, Middle, Le		ELLSWORTH	FOX		2. Dete of Dea Month October	_	OOO	3. Time of Death 11:30 AM
/Medical Examiner	4a Facility Name (If not institution, gir	re street and number)			4b. City, Town, or	Location of Death	4c. County		
Examiner	6315 Brown's Quan	ry Road			Sabillas			erick	
uneral irector	5. Sociel Security Number 219-01-0289	Sex 1 1 M 2 □ F	e (In yrs. lest birthdey 89 Yrs.) If Under 1 Yea Months Deys			, Year) , 1911	9. Birthpie Count Mary	ece (Stete or Forei ly) Land
3	Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10	ld. Inside City Limi
f show	Maryland Frederi	ck	Sabilla:						1 Yes 2 N
rect	10e. Street and Number	CK	Dabitia	10f. Zip Code			10g. Citizen of V	What Count	ry?
23a o	6315 Brown's Quar	ry Road		21780			U.S	.A.	
Examiner must be notified at by Funeral Director	11. Merital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Armed Forces? 1 Yes 2 Yes If Yes, Give Yeer or Detes:	Ever in U,S. 13.	Wes Decedent of If Yes, specify Cul	Hispanic Origin? (S ban, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	14. Rac Blac Specify	e - America ck, White, e	
"natural". ofice Em	15. Decedent's E		16a. Dece	edent's Usuel Occu	upation e during most of wo	orking	16b. Kind of Bu	usiness/Indi	ustry
	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or	5+) life.	DO NOT use retir	ed)				
marked other than imatic event, the M To Be Comp	8		Main	ntenance	Mechanic		Fort !		ie
ed of	17. Father's Neme (First, Middle, Last Willie R. Fox	,				th Shind			
e marked o eumatic ev	19a. Informent's Neme/Relationship	Type, Print)	19b. Mell	ling Address (Stree	et end Number or F				Code)
27 is r treu	Thomas W. Fox	(Son)	11 1	Locust Dr	rive, Thu	rmont, Ma	arvland	21788	8
r othe	20a. Method of Disposition		20b. Plece of Disp			Date	20c. Location -		
# P	1 Burlel 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Contro		Mt. Moria			11/2/00	Foxville	e, Ma	ryland
important: if lear 27 is marked other than any injury or other treumatic event, the M	21. Signature of Paperal Service Lice	Dillo			Pess of Facility & DAILEY & MAIN STRE				
	23a. Parti, Enter the disease, or con shock, or ment failure. USI only	pications the cause							Approximate Interval Between
sician edical iminer	Immediate Ceuse (Finel disease or condition resulting in deeth)	· REN	/	ILURE	(Ac				Onset and Death
in a		DEH	Y DRATIO	N					
physician and s the burial-transit sdical Examin	Sequentially list conditions, if any leading to immediate	0	Due to (or es e conse						
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury	c							
0 8	that initieted events resulting in deeth) Last		Due to (or es e conse	quence of):					
attendir for use		d						1	
the a	Pert II. Other significant conditions	contributing to death b	ut not resulting in the	underlying cause g	iven in Part I.	23b. Did t	obacco use co	ntribute to	the cause of deat
been signed by the attendi should be detached for use leted by Physician/I	CORONARY	ARTERY	Disc	EASE		101	Yes 2□No	3 Prob	ebly 4 ☐ Unkno
						24a. Wes perfo	an autopsy med?	eva	re autopsy finding
5 W D							/	of d	npletion of cause leeth?
Page Con						101	es 2 No	10	Yes 2 No
certificate has rector, page 2 Be Comp	25. Was cese referred to medicel axeminer?	Hospitel:				eth (Check only o	ne)		5 45
this ald	1 Yes 2 No	1 L Inpatie	ent 2 ER/Outpatie	ent 3LI DOA		Home 5 Resid			')
After funer funer flon	1 Neturei 5 ☐ Pending	28a. Dete of Inju (Month, De	y Year) 288. Time Injury	W	ork? ☐ Yes 2 ☐ No	200. Describe i	low injury occur	160	
el Director: After to led in by the funera Certification:	2 Accident Investigetion 3 Sulcide 6 Could not be determined	9	28f. Location (S City or Tox	Street end Numl m, Stete)	ber or Rure	Route Number,			
To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com			of my knowledge, dee f examinetion end/or in eted.						
To the	29b. Signeture end title of certifier	7.11			nse number		29d. Dete signe	d (Month, L	Day, Year)
· ·		yh	er	200	05458	0	Nov 1	01,5	2000
	30. Name and address of person who Wasim Fakhar, MD		leath (Item 23a) (Type ick Street		own, Mary			, 0	
State	31. Date filed (Month, Day, Year)		ar's Signeture						

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

36 6 / Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day Veer **Physician** ROMEO **EDMUND** GUILBERT 9:58 AM OCT 31 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, give street and number) Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Feb 20, 19 5 Social Security Number 6. Sex 14 M 2 F 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Months Days 84 Director Canada 142-10-1193 Usual Residence of Decedent with the Maryland 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2006 Franwall Avenue 20902 USA Funeral death 12. Was Decedent Ever In U.S. Armed Forces? 1∆ Yes 2 □ No If Yes, Give 156-175 Year or Detes: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, apecify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritel Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1□ Yes 2□ No Baltimore, Maryland 21215-0020 Specify: Specify: White py 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) i Hygiena. Elementery/Secondary (0-12) Coilege (1-4or 5+) permit. Peges 1 and 2 should be filed will Department of Heelth and Mental Hygien, Important: If Item 27 Is marked other the any Injury or other treatmetic event, trappose. 12 Analyst Federal Government 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Eugene Guilbert Rose Ann Sabourin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2006 Franwall Avenue, Silver Spring, MD 20902 Johanna Maria Guilbert / Wife 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other placa) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 11/3/00 Alexandria, VA Metropolitan Crematory 22. Name end Address of Facility Francis J. Collins Funeral Home, Inc. 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. MD 20901 Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final CONGESTIVE HEART FAILURE disease or condition resulting in death) Examiner Due to (or es e consequence of): Examiner that the death certificate be executed pue burial-tran Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): Box 68760 physician Physician/Medical the Due to (or as a consequenca of) 80 950 ò the bed 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. detach 3 Probably 4 Unknown been signed by should be detac 1 Yes 2 No by 24b. Were autopsy findings avelleble prior to completion of cause of death? 24e. Wes en eutopsy Completed certificata has page 2 26 No 1 ☐ Yes 1 Yes 2 No Division of Vital or Attending Physician: aftar death. Director: After this certifica 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Neturel 1 Yes 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 | Homicide To the Hospital e within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner stated. 29e. Certifier Medicai 29d. Date signed (Month. Day, Year) 29c. License number 29b. Signature and title of cartifier D-52862 +1 OI 2000 Wes Onlike 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600 KEVIN A. LT, MC, USN DORRANCE. 31. Date filed (Month, Day, Year) 32. Registrer's Signature State

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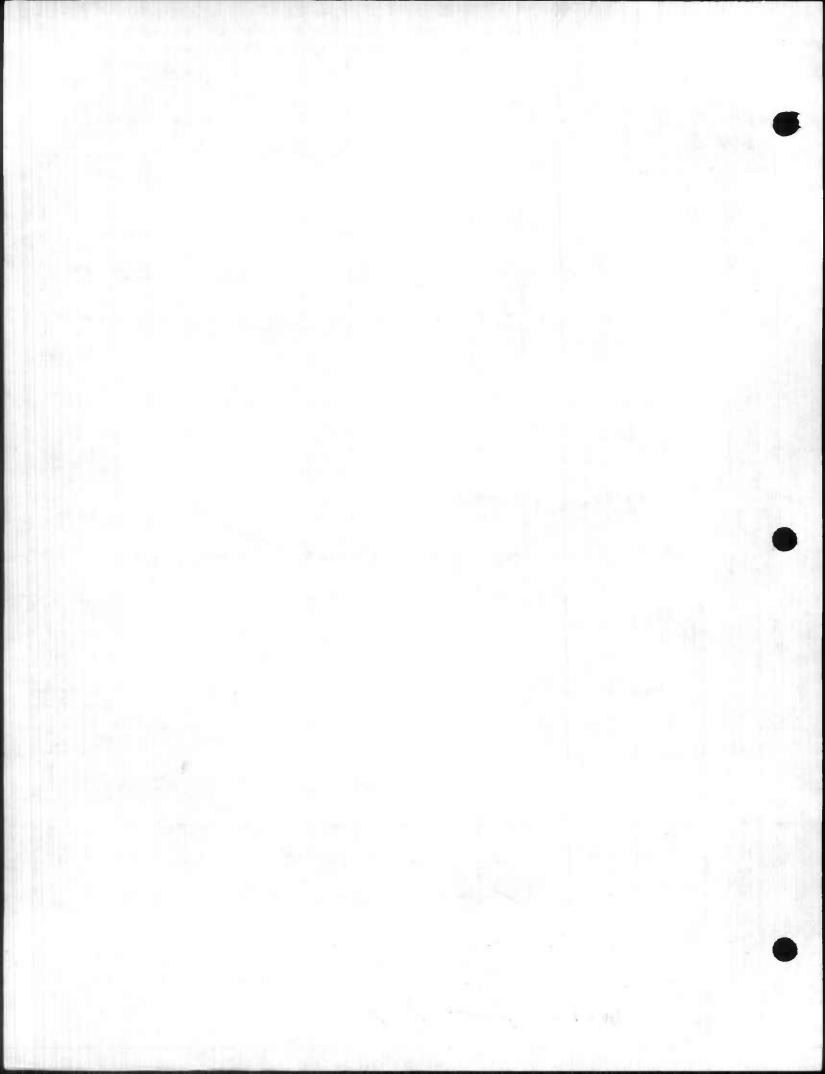
Registrar

02

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death October 29 2000 **Physician** 5:02 PM David Steven Graves /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 12403 Sturdee Drive Upper Marlboro Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Oct 9, 1943 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1₩ 2□F Months Maine 57 005-38-7766 Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d, Inside City Limits works / 1 ☐ Yes 2 ☐ No Director notifie Upper Marlboro Prince Georges 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? Berns 23s or must be 12403 Sturdee Drive 20772 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filled within 72 hours after 1 Yes 2 No If Yes, Give 1 ☐ Never Merried 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 ☑ No Specify: Specify: White ğ 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes:1962-66 Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiena. Elementery/Secondery (0-12) College (1-4or 5+) 5+ Program Analyst Federal Government permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked othe any injury or other traumatic event. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ag Richard A. Graves Elayne Snow 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Catherine Graves-Wife 12403 Sturdee Drive, Upper Marlboro, MD 20772 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriel 2X Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematory 10/30/00 Alexandria, VA 22. Name and Address of Fecility 21. Signeture of Funeral Service Licensee Metropolitan Funeral Service 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart teilure. List only one cause on each line. VA 22310 Approximete Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in deeth) . Multi lesions high quade Glioma, Brain /Medical Month Examiner Examiner physician and s the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting In deeth) Last Due to (or es e consequence of): P.O. Box 68760, Physician/Medical Due to (or es a consequence of): 88 signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed page 2 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No or Attending Physician: 8 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 1 Neturel
2 Accident 5 Pending 1 Yes 2 No 24 hours after death. investigetion 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier (Check only one) within 2. To the F \$ 29d. Date signed (Month, Day, Year)
October 30, 20 29c. License number 29b. Signature end fitle of certifler 20 lecupabe us D42049 2000 Kolin 6 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) Upper MARIboro. MO Alain CHAMPALOUX MD G. 31. Dete filed (Month, Dey, Year) 32. Pegistrer's Signeture State 2000 NOV 01 Registrar

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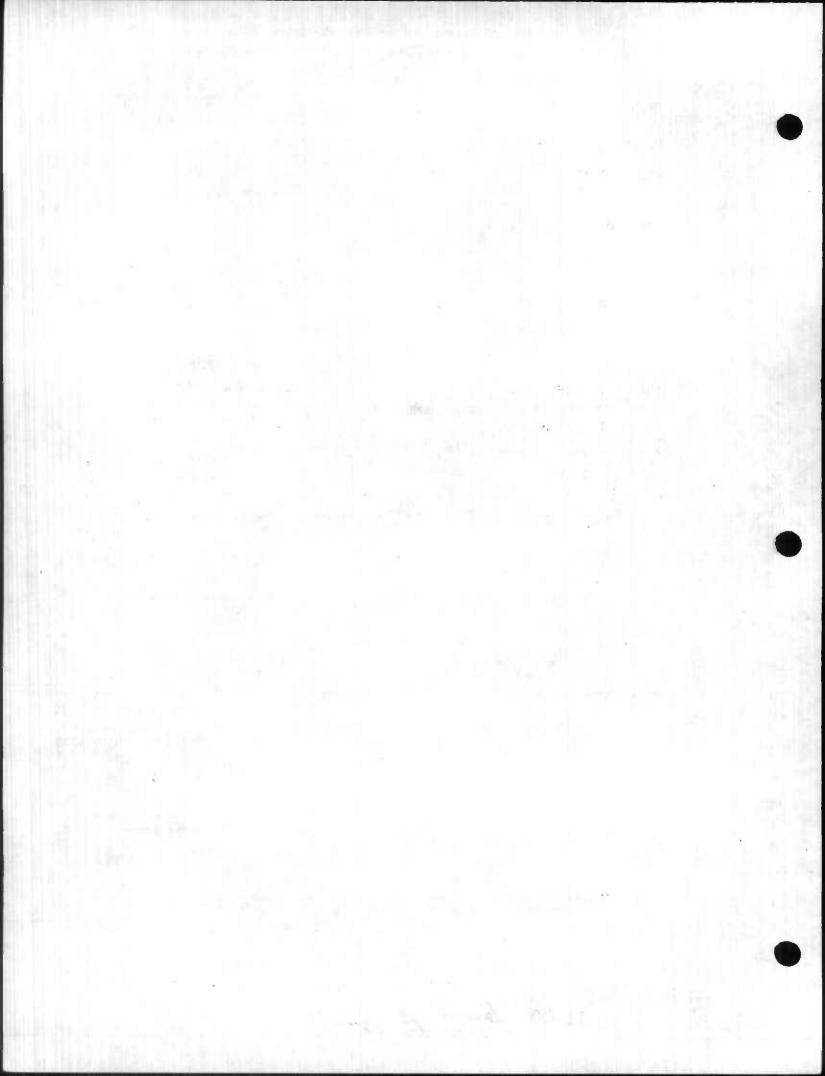


State of Maryland / Department of Health and Mental	Hygiene	361	60
Certificate of Death	Reg. No.	001	U.

			Certificate of	Death	Reg	. No.	001	0.0				
	1. Decedent's Nema (First, Middle, Last)				2. Deta of Death	Day		Time of Death				
sician	STEVEN M. GOSS				OCTOBER	27, 2	000	9:10 PM				
ledical aminer	4a Facility Name (If not institution, give street an	d number)		4b. City, Town, or Loc	cation of Death	4c. County	of Death					
	WOODSIDE GENESIS NUI	RSING HOME	1. The letter	SILVER S	PRING	MONT	GOMERY					
al	5. Social Security Number 6. Sex	7. Age (In yrs. last bi	inthday) If Under 1 Year Months Days		8. Date of Birth	(aar)	9. Birthplace (State or Foreign				
r	216-60-4853 1M 2	47	Yrs. Months Days	Hours Mill.	JUL 30,	1953	MARYLA	ND				
rector	10a. Stete 10b. County MARYLAND PRINCE GEO		vn or Location VILLE					side City Limits				
ā	10e. Street and Number		10f. Zip Code 2070.	5		g. Citizen of V USA	Vhat Country?					
era	13204 TANEY DR 11. Marital Stetus 12. Was	Decedant Evar in U.S.					a - American Inc	dien.				
by Funeral	1 Never Merried 2 Married 1 X If Ye	ed Forces? Yas 2□No 1973— s, Give or Detes: 1974	If Yes, specify Cul 1 ☐ Yas 2 ☒ No	Hispanic Origin? (Specien, Mexican, Puerto F	Rican, etc.)	Specify	ck, Whita, atc. WHIT	E				
Pe	15. Decedent's Education	168	. Decedent's Usuel Occu	pation	16	6b. Kind of Bu	usiness/Industry					
Completed	(Specify only highest grada completed in the complete in the content of the conte	ge (1-40r 5+)	i. Decedent's Usuel Occu (Give kind of work done life. DO NOT use retin PHOTOGRAPHE:		19	рното	GRAPHY					
	17. Father's Name (First, Middle, Last)	2	I MOTOGIQUE III	18. Mother's Neme	(First, Middle, Ma							
o Be	MILTON E. GOSS, SR.				E E. PHI							
ř	19e. Informent's Neme/Reletionship (Type, Print	10	b. Meiling Address (Stree				State Zin Code					
							_	,				
	FLORENCE GOSS/MOTHE	20b Place	13204 TANEY of Disposition (Name of				City or Town, S	tate				
	1 Burial 2 □ Cramation 3 □ Removel I	rom Stata cemete	ary, cremetory or other plant									
any injury once.	4 Donetion 5 Other (Specify)	GATE	OF HEAVEN				SPRING					
	21. Signature of Funeral Service Licensee	11800 NEW HAMPSHIPE AVE STIVER SPRING, MD 20904										
n al er	23a. Pent1. Enter the disease or complications is shock, or heart leilure. List only one ceuse Immediate Cause (Finel disease or condition resulting in deeth)	creatic Cano					Onse	oximate val Between et end Death				
Je je												
Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events	Due to (or es e	consequence of):			W						
edicai	Ceuse (Diseese or Injury that initiated events resulting in death) Lest	Dua to (or es e	consequence oi):									
3	d	35 11 31										
SIC	Pert II. Other significant conditions contributing	to death but not rasulting	In the underlying cause g	iven in Pert I.	23b. Did tob	acco use co	ntribute to the	cause of death?				
by Physician					1 🗆 Yes	2 □ No	3 Probably	⊉ ∭Unknown				
Completed b					24e. Wes en performe		eveileble	utopsy findings a prior to ion of cause ?				
E					1 ☐ Yes	2 X No	1 ☐ Yas	2 □ No				
BeC	25. Was case referred to medical			26. Piace of Deeth	(Check only one)						
ToB	axaminar? 1 ☐ Yes 2XXVIo Hospitel:	1 Inpatiant 2 ER/O	Outpatient 3 DOA	ther	ne 5 🗆 Residen		er (Specify)	77 F				
			Time of 28c. Injury		28d. Describe hov							
Certification:	3 Sulcide 6 Could not be	Plece of Injury - At home, fouilding, etc. (Specify)	erm, street, lectory, office		28f. Location (Stre City or Town,	eet and Numb State)	per or Rure/Rou	te Number,				
edical C	29a. Certifier (Check only one) (Check only one)							ceuse(s)				
Σ	29b. Signature and Aitle of certifier	00000	29c. Licer MO D3826	sa number			d (Month, Day, 1					
State	30. Nama and address of person who completed Dr. A. Mendhiratta, M. 31. Data filed (Month, Day, Year)			vard; Roc	kville,	MD 208	350					

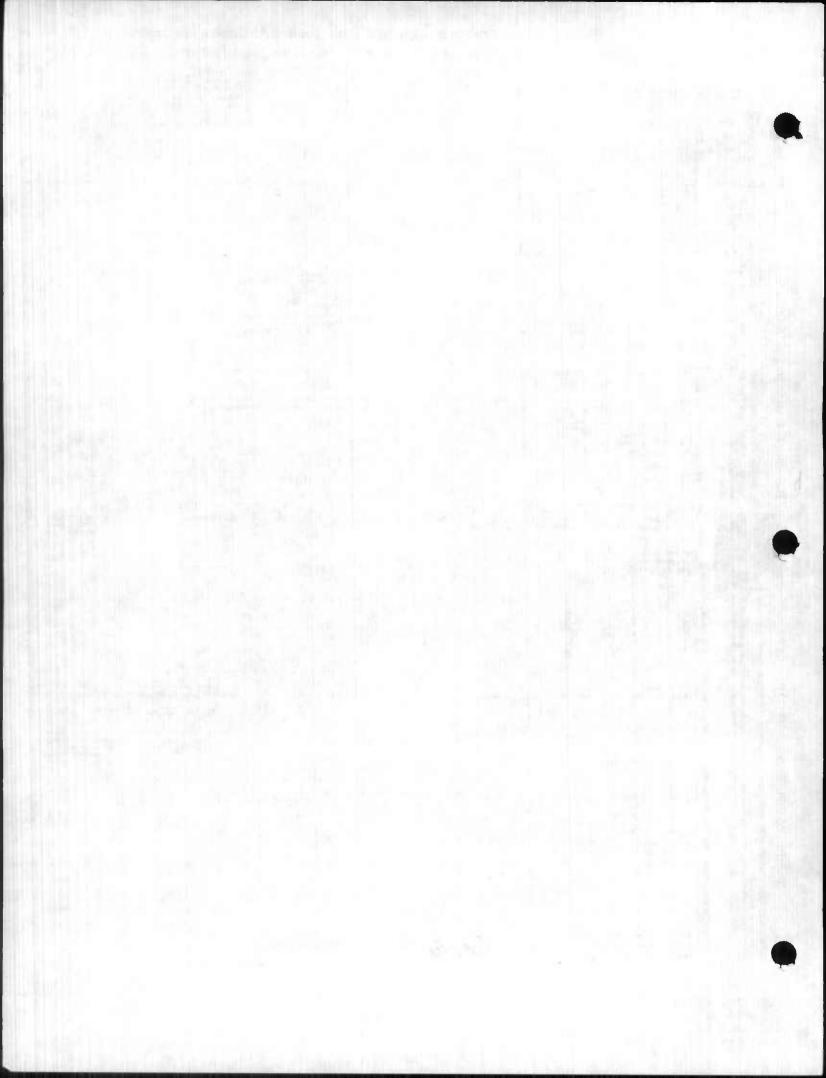
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NOV 0 1 2000



		State of Maryla	and / Depa		Health and	Mental Hy	0.5	36170				
	1. Decedent's Name (First, Middle, La	ist)			TESTON I	2. Date of De		3. Time of Death				
Physician /Medical	Saul Gold				4b. City, Town, or	Month Octobe	r 31, 200					
Examiner	4a Facility Name (If not Institution, git		To a second from C									
	Fox Chase Rehabil		rs. last birthday)		Silver S			gomery				
Funeral Director		Sex 7. Aga (In y		Months Days				Birthplace (State or Foreign Country) WYORK				
Manyland f ahow ed at	10a. Stata 10b. County Maryland Montgom		City, Town or Lo					10d. Inside City Limits 1				
free death with the Ma r items 23s or 28s-fr other must be nother funeral Directo	10e. Street and Number 4450 South Park A	venue Apt. 40)5	10f. Zip Code)815		10g. Citizen of Who					
To be Completed by Functional Director To Be Completed by Functional Parts of the Control of th	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 3 Yas 2 No If Yes, Giva WW Year or Dates.		Was Decedent of It Yes, specify Cu 1 ☐ Yes 2√2 No	Hispanic Origin? (S ban, Maxican, Puar Specify:	Specify Yes or No to Rican, etc.)	Black,	American Indian, White, etc. White				
ed within 72 hos organia. or than "natura ft, in water II.	15. Decedent's E (Specify only highast gra Elementary/Secondary (0-12)		(Give		upation a during most of wo ed)		16b. Kind of Busin					
d will	12	5+	Exec	cutive			Non-Prof	it Organization				
s 1 and 2 should be filed. I has the and Mental Hyg tem 27 is marked other other traumatic event,	17. Father's Name (First, Middle, Last Meyer Goldbe)				me (First, Middle, pector	Maiden Sumeme)					
od 2 should had by the mark traumary traumary	19a. Intorment's Name/Relationship (Jill Beth Cutler				et and Number or Ri			ate, Zip Code)				
	20a. Method of Disposition	206	. Place of Dispo	sition (Neme of		Date	20c. Location - Ci	ty or Town, State				
Paga nent o int: If	1 Burial 2 Cremation 3 E	Me	dical C			2000	Washingt	on, D.C.				
permit. Departi Importa any inje	22. Name and Address of Facility Columbia Mortuary Services, Inc. P.O. Box 58007 Washington, D.C. 2003											
Physician /Medical Examiner	Par Enter the disease, or con or heart tailure. List only Immediata Causa (Final disease or condition	plications that caused the done cause on each line. Myocardial			ring, such as cardia	c or respiratory a	rest,	Approximete Interval Between Onset and Death Immidiate				
ō	resulting in deeth)	b Arterioscl	o (or as a consec erotic		scular D	isease						
be associted bidgen and burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	0.	(or as a consec									
that the death certificate I that the death certificate I death of the attending physical detached for use as the I by Physician/Medici	that initiated events resulting in death) Last	Dua to	(or as a consec	uenca ot):								
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by the tache	Part II. Other significant conditions of Sacral Decubitu		resulting in the u	nderlying cause g	iven in Part t.			ibuts to the cause of deeth? Probably 4\lambda Unknown				
aw requires se been sign 2 should be							an autopsy med?	24b. Wera autopsy tindings available prior to completion of cause of death?				
The law ate has the page 2 second						10	res 200No	t ☐ Yes 2 ☐ No				
certificate rector, pa	25. Was case referred to medical				26. Place of De	ath (Check only o	ne)					
	examiner? 1 Yes 20 No	Hospitel: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DOA	ther:		dence 6 Othar	(Specify)				
- P - P - C	27. Manner of Death 1 Natural 5 Pending 2 Accident Invastigatio	28a. Date of Injury (Month, Day Year,	28b. Time o	f 28c. Inj			now injury occurred					
To the Hospital or Attending P within 24 hours after death to the Funeral Director. After the Completaly filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined	e on place of laine. At	t home, tarm, str poify)	reet, tactory, office	9	28t. Location (: City or Tox	Street and Number vn, State)	or Rural Routa Number,				
To the Hospital within 24 hours at To the Funeral Completaly filled		ysician: To the best of my k niner: On the basis of exami and manner stated										
To the within To the comp	20b. Signatura user office of asserber	8C/x	My 4		nsa number 01120		29d. Data signed (October	Month, Day, Year) 31, 2000				
	30. Neme and eddress of person who Walter E. Gooz				e, Silve	r Spring	, MD 209	002				
State Registrar	31. Data filed (Month, Day, Year) NOV 0 2 20	32. Registrar's Sk	gnature g.	Sports								

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State of Maryland / Department of Health and Mental Hygiene	00	36	1	7
Certificate of Death Reg. No.				

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	miner	4a Facility Name (If not institution UNIVERSITY (OF MARY	LAND	MEDIC				BALT	TIMOF					
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urs after dear al', or flams Examiner ms	by Funeral	11. Merital Stetus 1 Never Married 2 Mai 3 Widowed 4 Divorce	rried 1	as Deceder med Forces Yes 2X Yes, Give ear or Detes	3?] No		Was Decede If Yes, specif 1 ☐ Yes 2	fy Cube	spanic Orig n, Mexican Specify:	in? (Spe , Puerto I	ocify Yes or No Rican, etc.)	Blac	e - America ck, White, et :: AFRC	c.	ERICAN
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Mantal Hyg wheel other stic event,	To Be C	17. Fether's Name (First, Middle JIM BROO)								r's Name		, Maiden Sumen ROLL			
- SHM N		19a. Informant's Name/Relation JENNIFER L. GO	Ship (Type, P.OLATT ,	rint) / DAUG	SHTER							PRNIE, MI			
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eeth certificate be ex attending physician of for use as the burial	n/Medical	that initiated events resulting in death) Last	d		Due to (or	r as a conseq	uenca of):								
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hat the detac		CONGESTIV	Pert II. Other significant conditions contributing to death but not resulting in the underlying CONGESTIVE HEART FAILURE							23b. Did tobacco uss contributs to				Unknown	
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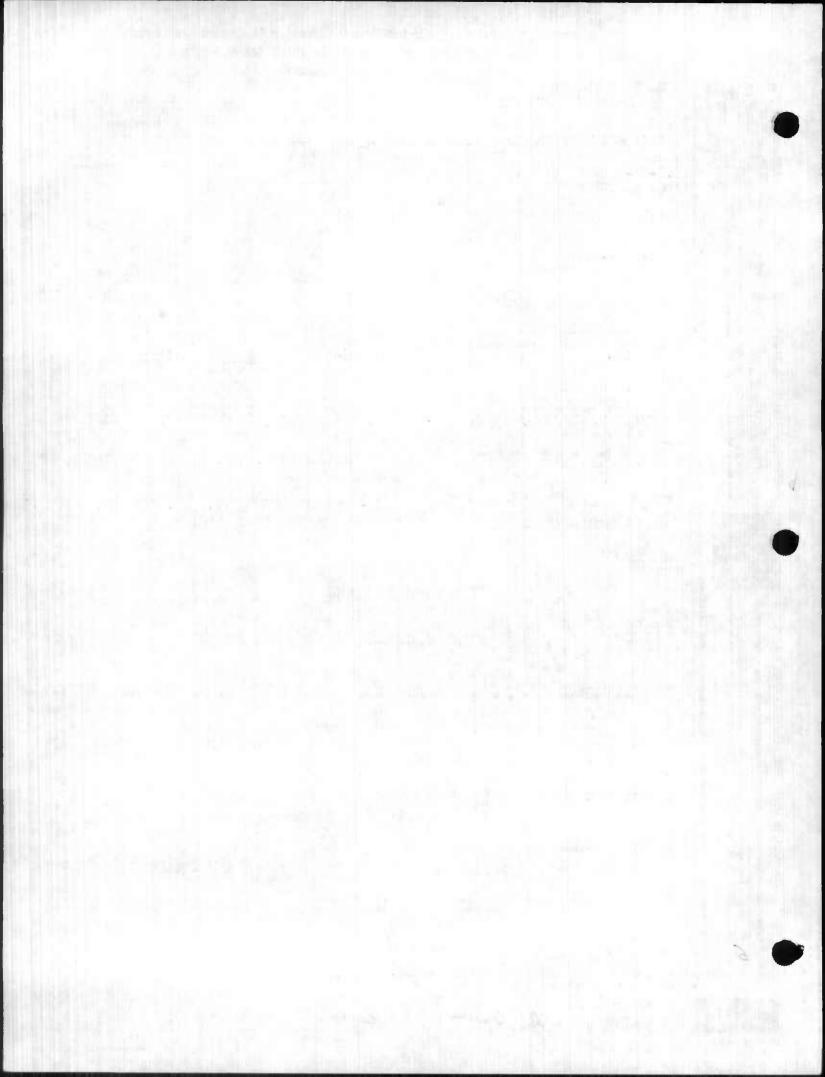
State Registrar

NOV 0 2 2000

31. Date filed (Month, Day, Year)

32. Registrar's Signeture

30. Name and address of person who completed cluse of death (Item 23a) (Type Print)
Merrill Sparago 22 South Greene Baltimore, MD 21201



State of Maryland / Department of Health and Mental Hygiene 0 36 172

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Funeral Director	5. Social Security 1 236-42-		Sex 1□ M 2](0 F	Age (In yrs. 88	last birthday) Yrs.	If Under Months	Days	Hours	Min.	8. Date of Birth (Month, Day, OCT. 29	Year) 1911		lece (State or Fore try) YORK
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Health and Mental Hygiene. tem 27 is marked other than other traumatic event, ma. M. To Be Comp		JOHN	D	AVIS						REBECCA	DAV	/IS	
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31 THE PERSON NAMED IN COLUMN . B planter of the mental and CHIEF CONTROL OF STREET STREET, AND THE PARTY OF THE PART

State of Maryland / Department of Health and Mental Hygiene

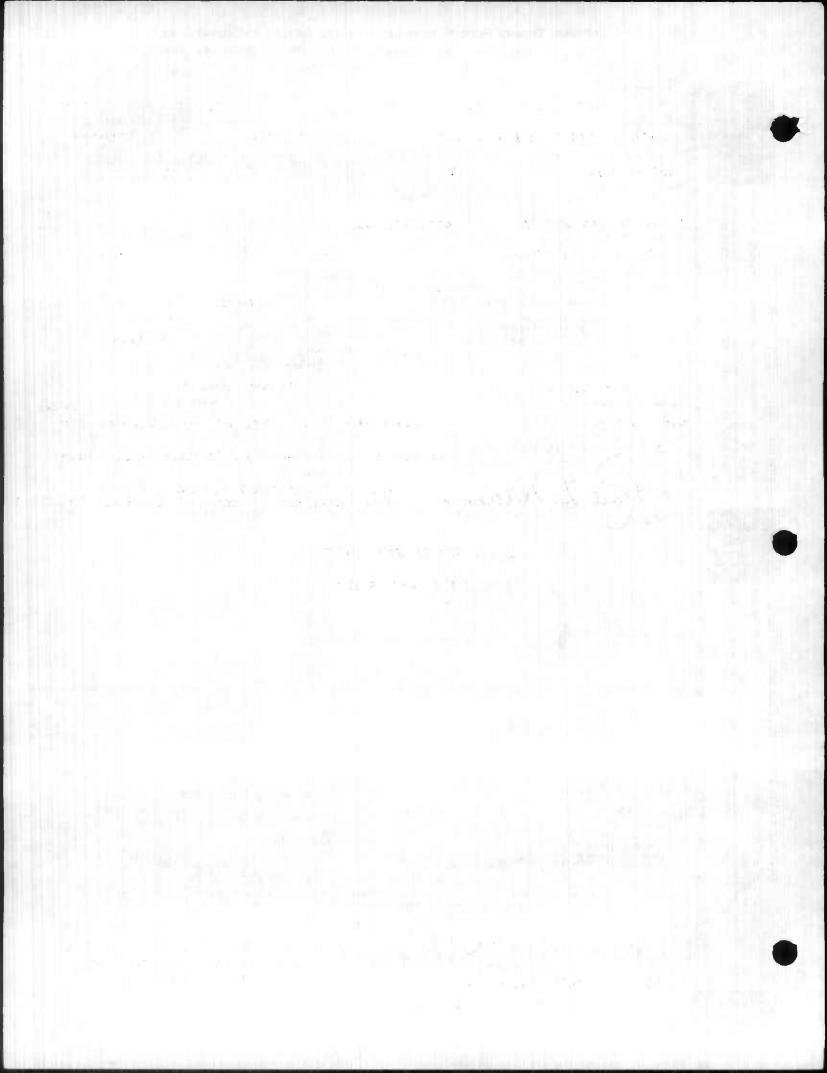
Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dey **Physician** HENRY MEDRANO GOMEZ OCT 14 2000 7:53 PM /Medical 4b. City, Town, or Location of Deeth 4e Fecility Name (If not institution, give street end number) 4c. County of Deeth Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5 Sociel Security Number 6. Sex 12 M 2□ F 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dev. Yeer) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours Yrs. 461-22-3614 80 Director July 15, 1920 Texas Usuet Residence of Decedent permit. Pages 1 end 2 should be filled within 72 hours efter death with the Meryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or hems 23s or 2se." 10a Stete 10h County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland Montgomery Gaithersburg 10e. Street and Number 101. Zip Code 10g. Citizen of Whet Country? 23011 Wild Hunt Drive 20882 U.S.A. Funeral 12. Wes Decedent Ever in U.S. Armed Forces?

1⊠ Yes 2□ No 1939 If Yes, Give Yeer or Dates: 1972 Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. Bleck, White, etc. 1 Never Married 2 Married 1X Yes 2 □ No Specify: Specify: White by 3 Widowed 4 Divorced Mexican Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) U.S. Army 12 First Sergeant 18 Mother's Name (First Middle Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Medrano Diego Gomez Susana 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 20882 19e. Informent's Name/Reletionship (Type, Print) Mary E. Gomez - Wife 23011 Wild Hunt Drive, Gaithersburg, Maryland 20a. Method of Disposition 20b. Plece of Disposition (Neme of cametery, cremetory or other pleca) Dete 20c. Location - City or Town, State 1 X Buriel 2 Cremetion 3 Removel from State Arlington National Cemetery 10/25/00Arlington, Virginia 4 Doneton Other (Specify) 21. Signeture of Funera Servica Licanse 22. Name end Address of Fecility Olin L. Molesworth P.A., Funeral Home 23a. Pert1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or earl eiture. List only one cause on each line. 20872-011 Approximate Intervet Between Onset and Deeth **Physician** /Medicai immediate Cause (Final MULTI SYSTEM ORGAN FAILURE diseese or condition resulting in deeth) Examiner Due to (or as e consequence of): Examiner CONGESTIVE HEART FAILURE physicien and the bunel-transit requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequença of) Records. P.O. Box 68760. Physician/Medical Due to (or es a consequença of) 89 for use es signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 ♥ Unknown à 24b. Were eutopsy findings evailable prior to completion of cause of deeth? been si Completed 24a. Wes en eutopsy performed? The law s certificate has t 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: director, Be 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospitet: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 1 Yes 2♥ No 1∑ Inpatient 2 □ ER/Outpatient 3 □ DOA this After this 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 ⊠Naturel 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No n 24 hours after deeth.

Be Funeral Director: A pletaly filled in by the fi deeth. investigation 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 | Homicide Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the ceuse(s) end menner as stated.

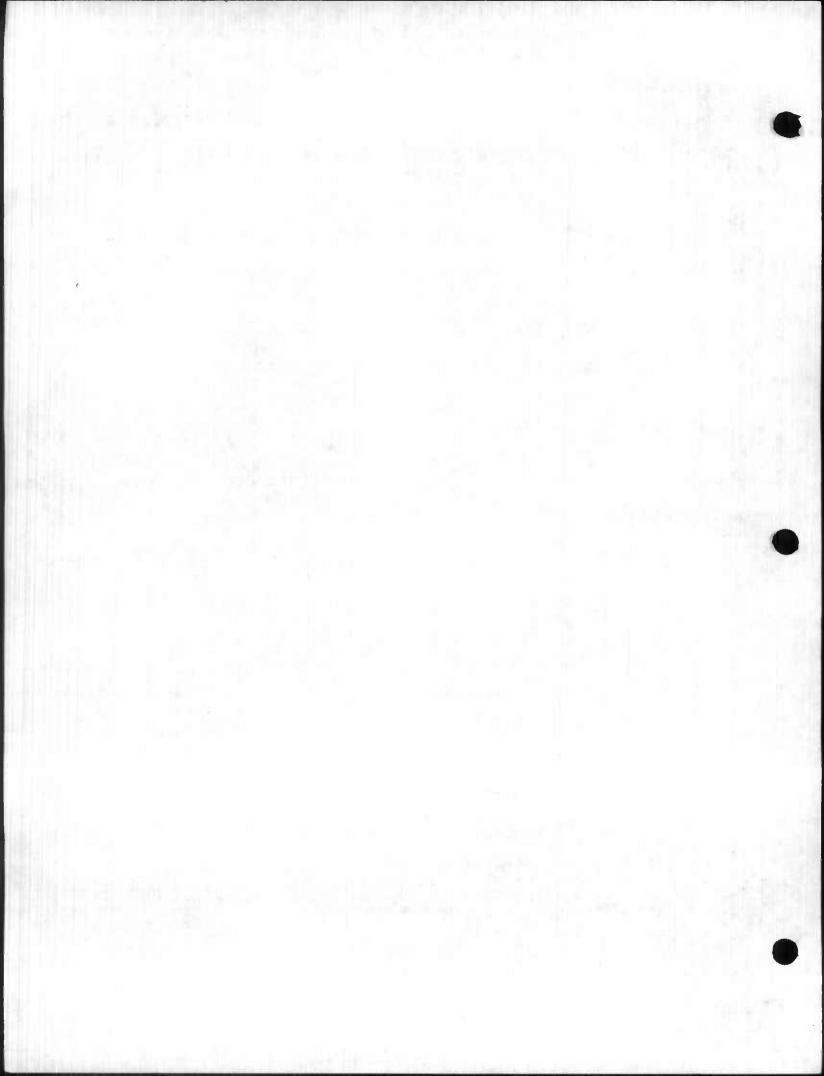
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, and due to the ceuse(s) end manner stated. 29e. Certifie edical (Check only one) within 2 To the the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end fitle of cartifier 16 2000 0101-840557 (VA) nu 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600 JOHN T. BASSETT, LT, MC, USN 32. Registrar's Signeture State 7 2000 Sports Registrar

DHMH 16 Ray 6/95



		State	of Marylan		irtment of F tificate of	lealth and N Death		jiene 🔰 leg. No.	U	66174		
1.4.	1. Decedent's Name (First, Middle	e, Last)					2. Date of Dea Month	th Day	Yeer	3. Time of Death		
Physician /Medical	JOHN '	THOMAS	GILBERT	7			OCTOBER		000	5:45 P.M.		
Examiner	4a Facility Name (If not institution	n, give street and n	u <i>mber)</i>			4b. City, Town, or L	ocation of Death	4c. County				
201	Frederick Memo	rial Hos	oital			Frederic			leric	k		
Funeral	5. Social Security Number	6. Sex 1 M 2 ☐ F	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey	Year)	9. Birthp	lace (Stete or Foreign try)		
Director	220-16-0528	W 2017	77	Yrs.			Dec. 14	, 1922	Mary.	land		
pu k	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Los	cation				11	Od. Inside City Limits		
Manyl f sh	W1 1 F1	1 - 1 - 1 -	77-	11	.11					1 ☐ Yes 2 No		
the liber	Maryland Fred	lerick	wa.	lkersv	10f. Zip Code		1	Og. Citizen of V	What Coun	try?		
Man of H	9717 Woodsboro	Pike			21793	3		United	Stat	100		
iter death with the Ma r items 23a or 28e-fa iner must be notified Funeral Director	11. Marital Status	12. Was De	cedent Ever in U,	S. 13. V	Vas Decedent of H	lispenic Origin? (Sp	pecify Yes or No-	14. Rac	a - Americ	an Indian,		
filed within 72 hours after death with the Maryland Hygiene. Hygiene. If he Medical Examiner must be notified at the Medical Examiner must be notified at a Completed by Funeral Director.	1 Never Merried 2 Merried 3 Widowed 4 Divorced	If Yes. G	2 XNo		Yes, specify Cuba	Specify:	Rican, etc.)	Specify	ck, White, o	etc. iite		
2 hor	15. Deceden	t's Education		16e. Deced	ent's Usual Occup	pation		16b. Kind of Bu	usiness/Ind	lustry		
hin 7	(Specify only highe Elementary/Secondary (0-12)	T	(1-4or 5+)	life. E	KIND OF WORK DONE OO NOT use retired	during most of world)	king					
d with the that the that the the the the the the the the the th	11			meat	cutter			Trout's	marl	ket		
should be filed within 72 ho of Mental Hygiene. marked other than "natur imatic event, the Medical. To Be Completed	17. Father's Name (First, Middle,	Last)				18. Mother's Nam	ne (First, Middle,	Maiden Suman	10)			
should be ind Mental marked umartics	John E. Gilbe	rt				Amy	Filler					
2 sho	19a. Informant's Neme/Relations	hip (Type, Print)				and Number or Ru				Code)		
127 t	Josephine Gilbe	rt/ wife				oro Pike,				21793		
Peges 1 a nent of Hea int: If Item iry or othe	20a. Method of Disposition	3 ☐Removel from	C	lece of Dispos emetery, cren	sition (Neme of netory or other plea		Date	20c. Location -				
	4 ☐ Donation 5 ☐ Other (S				pel Ceme		10/31/00	Libert	ytown	, MD		
pemit. Pege Department of Important: If any injury or once.	21. Signature of Funeral Servica Licensee 22. Name and Address of Facility Charles Funeral Home											
70 F 9 9	23a. Part . Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.											
Physician /Medical Examiner	Immediate Ceuse (Finel disease or condition resulting in death)	a	SMA		ر لریاد			, Sy	1 1 1 1	Onset and Death		
at the death certificate be assecuted to by the attending physician and etached for use as the burial-transit. Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last	c		as a consequence								
death e atten ed for u	Part II. Other aignificant condition	one contribution to	death but not resu	ulting in the ur	nderlying cause giv	ven in Pert I	23h Did to	obacco usa co	ntribute to	the cause of death?		
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es the	CHRONC	DBS-choc	THE PUI	Lucus?	y Disease	38			,			
requir	DIAGGE	55					24e. Wes a perfor		9V	ere autopsy findings allable prior to mpletion of cause death?		
The la	Cauch	d.1 . D. 4.					1 D Y	es 2 No	10	∃Yes 2□ No		
nysician: The law his certificate has to director, page 2 s	25. Was case referred to medica		1 LEG			26. Place of Dea	th (Check only o	- / /				
Physician: this certific and director, TO Be	examiner?	Hospitel:	napatient 2	ER/Outpatien	t 3 DOA Ott	30r	ome 5 Resid		ner (Specif	v)		
filer ti unera	27. Manner of Death 1 Natural 5 Pendir 2 Accident investi	28a. Date (Mo	e of Injury onth, Dey Year)	28b. Time of Injury	28c. inju		28d. Describe h					
al or Attending P rs after death. el Director: After ted in by the funer Certification:	3 Sulcide 6 Could 4 Homicide determ	ined 286. Plet	ce of Injury - At ho ding, etc. (Specif)	me, ferm, str	eet, factory, office		28f. Location (S City or Tow		ber or Rura	I Route Number,		
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi Medical Certificati												
To the Common	29b. Signature end little of contribe				29c. Licens			29d. Date signe				
		1/1/	~D		D.	32171		10/	27/0	6		
	30. Name and address of person				CM ST.	WALKER	BVILLE		793			
State	31. Date filed (Month, Day, Year)	32.	Registra/s Signa		6 6	restar						
Registrar	UUI	3 0 2000	Digas V	/	1900	7/03/						

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death OCTOBER 29, 2000 **Physician** BERTHA JUNE GEISLER 2:07 P.M. /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Undar 1 Yaar If Undar 24 Hrs. Birthplaca (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Days Hours 1□ M 2□ F Months Yrs Director 216-12-6084 78 06-05-1922 MARYLAND Usual Rasidence of Decedant the Maryland 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yas 2 No Directo MARYLAND FREDERICK THURMONT 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Coda 13001 LAYMAN ROAD 21788 UNITED STATES Funeral 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11 Marital Status Was Decedant Evar in U,S. Armed Forcas? 72 hours after 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yas 2 No Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: WHITE þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry tiled within 7 I Hygiene. other than "n Elamentary/Secondary (0-12) Collega (1-4or 5+) HOUSEKEEPING is marked other 18. Mothar's Nama (First, Middla, Maidan Surnama) 17. Fathar's Nama (First, Middla, Last) Be 1 end 2 should be Health end Mental ROY AUSTIN CANNON BERTHA MAE LINTON CANNON 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Code) permit. Peges 1 end 2.
Depertment of Health el
Important: If Item 27 Is
any Injury or other tree LANA M. BURKETT/ DAUGHTER 13001 LAYMAN ROAD, THURMONT, MARYLAND, 21788 20b. Place of Disposition (Nama of camatary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 Donation 5 □ Other (Specify) RESTHAVEN MEMORIAL GARDENS 11-01-2000 FREDERICK Signature of Funeral Service Licenses 22. Nama and Addrass of Facility Stanffer Funeral Hours, P.A. To not antar the mode of dying, such as cerdiac or respiratory arrast, Approximata Interval Batween Onsat and Daath 23a. Parti. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each tine. **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Examiner Dua to (or as a consaquance of): Examiner ettending physicien and for use es the bunal-transit Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Dua to (or as a consequanca of): Box 68760. certificate be Physician/Medical Dua to (or as a consaquance of): P.O. Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown his tony of ischamic Records, p 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed inopypmal atrial has 1 Yas 20 No 1 ☐ Yas 2 ☐ No Division of Vital 25. Was case referred to Be 26. Placa of Daath (Check only ona) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) al or Attending Physics after death. 2 1 Yas 2 No 1. Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 28b. Tima of 27. Manner of Death 28d. Dascribe how injury occurred 28c. Injury at Work? edical Certification: 5 Pending invastigation + Natural 1 ☐ Yas 2 ☐ No 2 Accident 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 3 Suicida 6 ☐ Could not be datarmined 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida To the Hospital e within 24 hours a To the Funeral D tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signatura and little of certifie 29d, Data signad (Month, Day, Year) 29c. Licansa number 30. Name and address of persu d ceusa of death (Item 23a) (Type, Print)

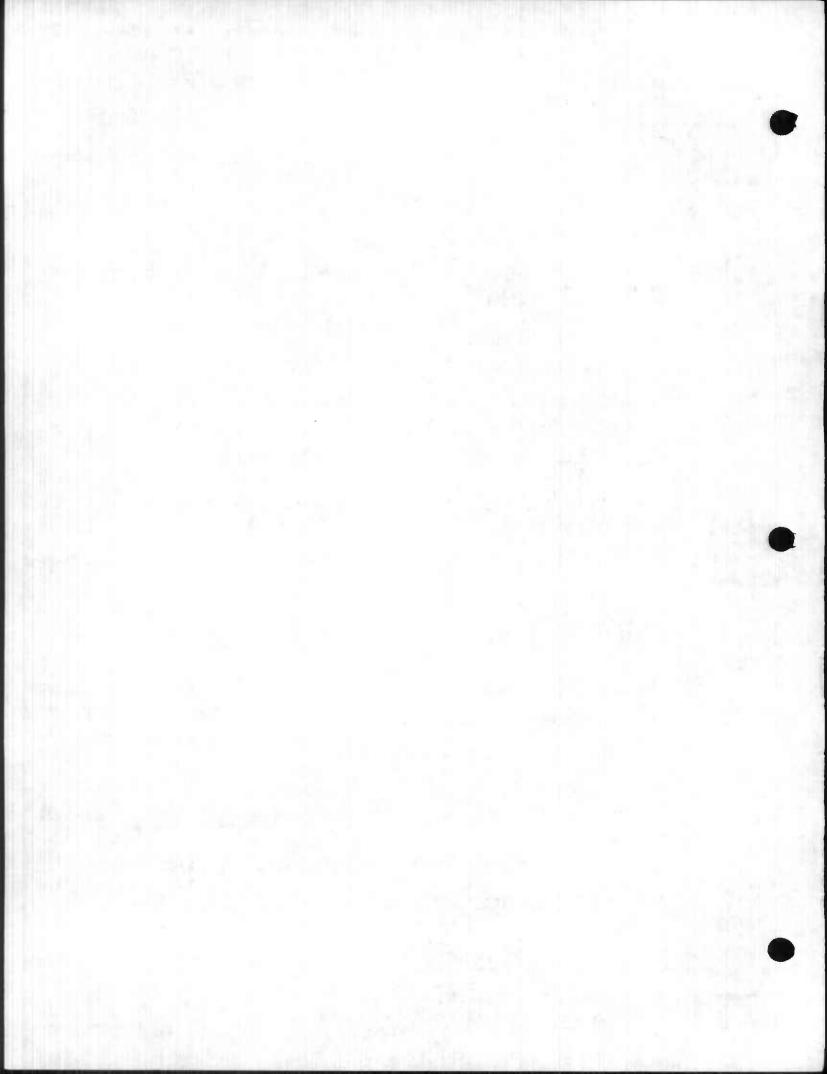
State Registrar

31. Data filed (Month, Day, Year)

NOV 0

32. Registrar's Signatura

2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 31, 2000 Joseph William Hunt October 1115 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street and number) Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. Months Deys Hours Min. 8. Dete of Birth (Month, Dey, Year)
Sept. 20, 1914

8. Birthplece (State or Foreign Country)
North Carolina 5. Social Security Number 6. Sex 7. Age (In vrs. last birthdev) Deys Months 1 X M 2 F 86 241-10-4512 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Maryland | Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4705 Chestnut Street 20814 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 Never Merried 2 Merried Specify: White 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Kodak Processing Elementery/Secondary (0-12) College (1-4or 5+) Lab Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Joseph Penn Hunt Odella Royster 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) Elaine M. Hunt/Wife 4705 Chestnut Street, Bethesda, Maryland 20814 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from Stete 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Steta Nov 4 2000 Oxford, North Carolina 4 ☐ Donetion 5 ☐ Other (Specify) Elmwood Cemetery 21. Signeture of Funerel Service Licenses 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ M00803 Bethesda, Chevy Chase, Inc. 7557 Wisconsin Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Causa (Finel disease or condition resulting in death) Cardiopulmonary Arrest Immediate Due to (or es e consequence of) 48 Hours Brain Hemorrhage Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Brain Herniation 48 Hours that initieted events resulting in death) Last Due to (or as a consequence of): Part It. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were sutopsy findings svailable prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred

Examiner that the death certificate be axec the USB BS unt, Joseph 10/31/00 certificate has Da09 2

Physician/Medical Examiner Completed 80 Certification: To After after death.

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Medical

(4) 20

State

Registrar

Physician

/Medical

Examiner

Directo

Funeral

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Completed

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Funeral

Director

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8 must be 238

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72 hours after

12 should be tilled within 73 n and Mental Hygiene. Is merked other than "ne

Pages 1 and 2 arment of Health an Health Item 27 i

Physician

/Medical

Baltimore, Maryland 21215-0020

25. Wes case referred to medical 1 Yes 2 No 27. Manner of Death

1 Neturel 5 Pending Investigation

2 Accident 3 Suicide 6 Could not be determined 4 Homicide

28a. Dete of Injury (Month, Dey Year)

and manner steted

Injury Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28c. Injury et Work? 1 Yes 2 No

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s)

281. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the causa(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) 10-31-00

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Steven Warach, M.D. 36 Convent Drive, Bethesda, Maryland

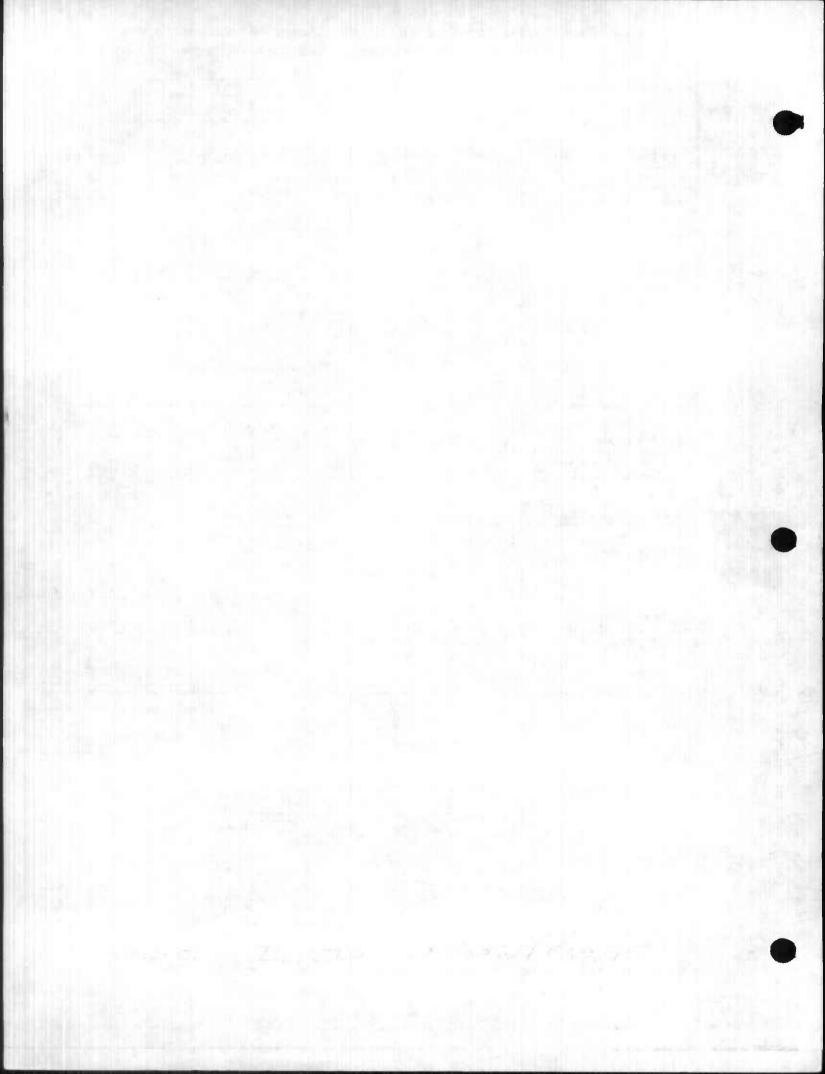
31. Date filed (Month, Day, Year)

29e. Certifier

NOV 03 2000 32. Registrer's Signeture Dinewa

24 hours a

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year LLOYD CHARLES HUBBARD 27,2000 OCTOBER 2:45 PM /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** WILSON HEALTH CARE GAITHERSBURG MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 15M 20 F Yrs. Director 126 01 0654 NOV.1.1909 NEW YORK Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. MONTGOMERY GAITHERSBURG 1 Yes 2 No Director or Herrie 23a or 28e-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 333 RUSSELL AVENUE #307 20877 Funeral UNITED STATES 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. permit. Pages 1 and 2 should be fliad within 72 hours ahar Department of Health and Mental Hygera. Important: If less 27 is marked other than "natural", or he any injury or other traumatic event, the Medical Exemina. 1' Never Merried 2 Merried 1 Yes 2 No If Yes, Give Yeer or Detes: Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) THEATER 12 **ACTOR** 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **GEORGE** Μ. HUBBARD SARA J. THOMPSON 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) GEORGE T. HUBBARD, JR., NEPHEW 23 MD. AVENUE, GAITHERSBURG, MD. 20877 Saltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Buriel 2 DCremetion 3 ☐ Removel from Stete METROPOLITAN CREMATORY 4 Donetion 5 Other (Specify) 10/29/00 ALEXANDRIA, VA. 21. Signeture of Funerel Service Licenses 22, Name and Address of Facility
MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical **Examiner** Due to (or es a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest attending physician and for use as the burial-tran Due to (or es a consequence of) P.O. Box 68760. Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 6 1 Yes 2 No 3 Probably 4 Unknown trectine Records, PV 24b. Were sutopsy findings available prior to completion of cause of death? director, page 2 should Be Completed 24e. Wes an autopsy certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending Investigation 1 Naturel il or Attending safter death. To the Hospital or Attendit within 24 hours after death.
To the Funeral Director: All completely filled in by the fu 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) m 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

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31. Dete filed (Month, Dey, Year)

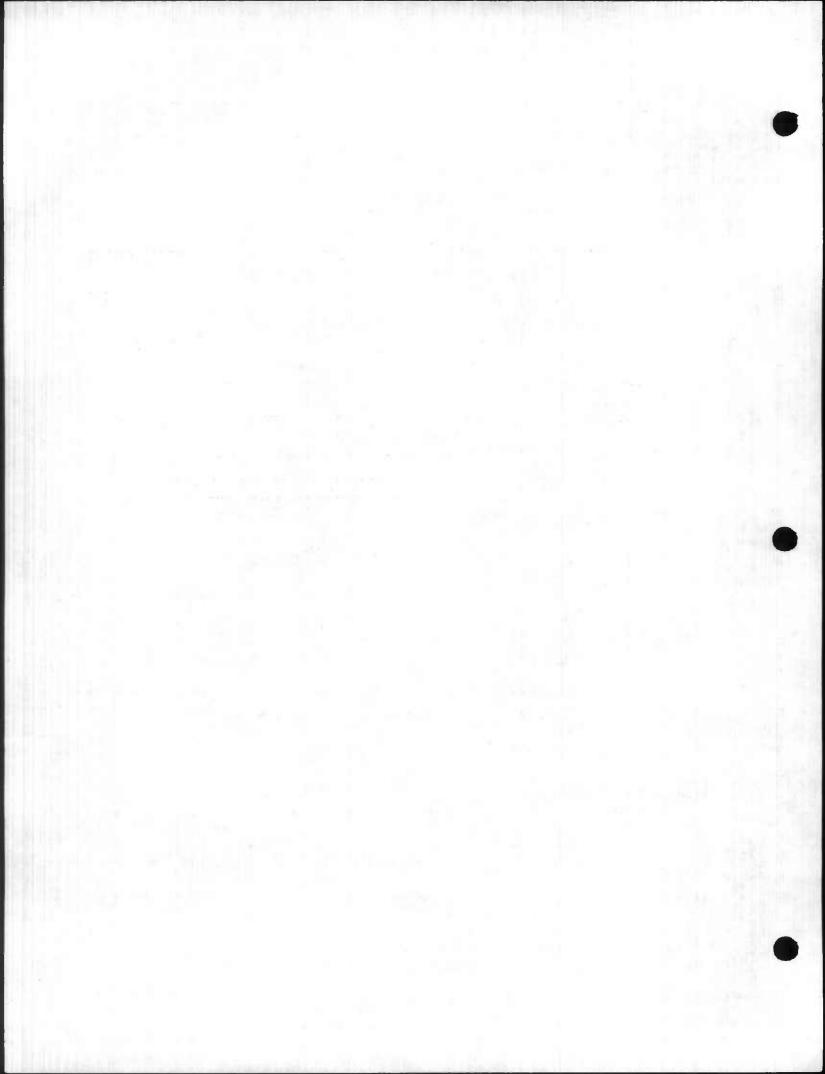
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32. Registrer's Signature

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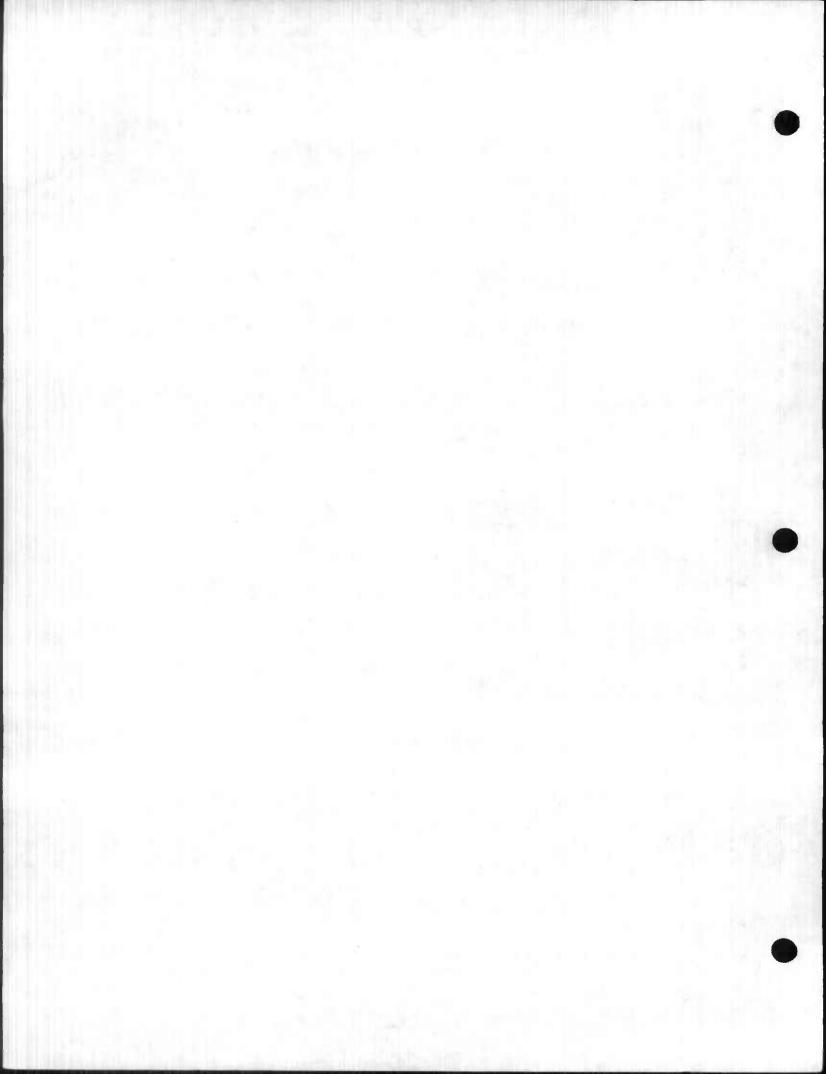
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State of Maryland / Department of Health and Mental Hygiene

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Baltimore,	-ISS	20e. Method of Disposition		20b. Placa of D	isposition (N	leme of		Dete	20c. Location -			
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Death Month 3. Tima of Death

Physician
/Medical
Examiner

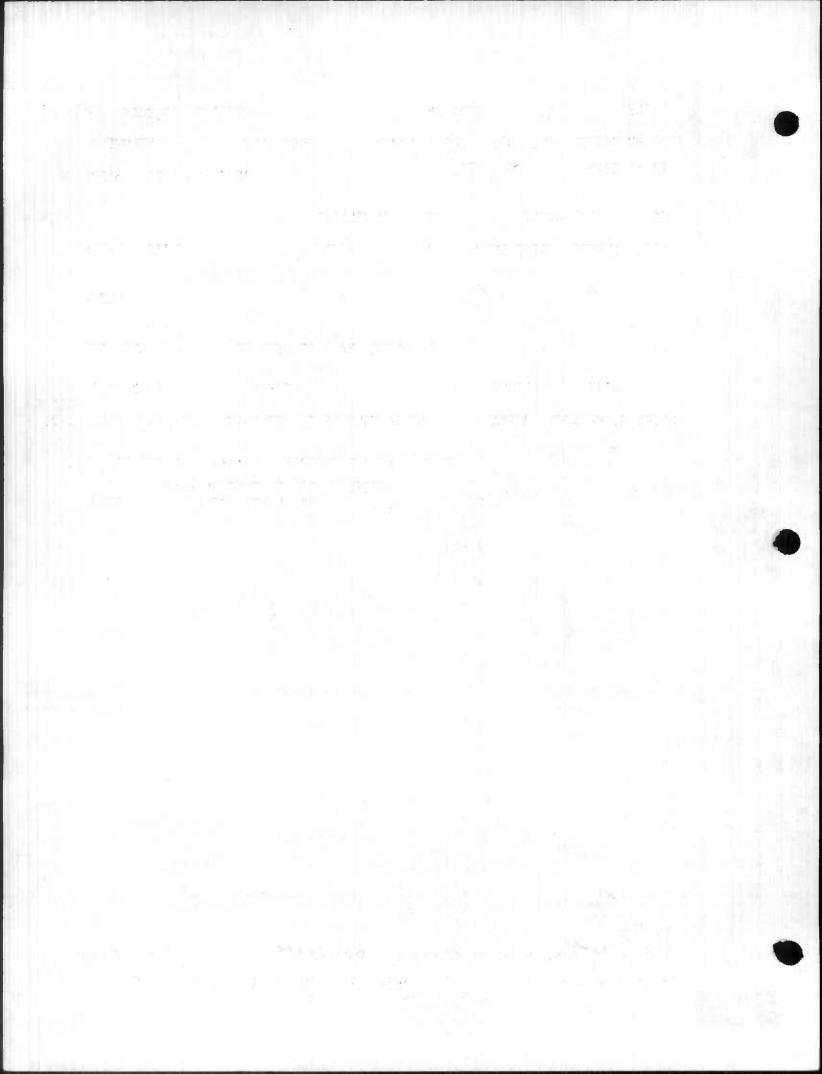
/Medi Exami		ical	ELVA M. HERSHEY 4a. Facility Name (If not institution, give street and number)					4b. City, Town, or	R 27,2000 6:18 PM				
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h	Funeral Director		5. Sociel Sacurity Number 213 24 3312 1 M 2 SF 7. Age (In yrs. last birthday) If Undar 1 Year If Undar 24 Hrs. Months Days Hours Min. (Month, Day, Year) APRIL 24.192							rth ay, Year) 24,1928	9. Birthplace (Stata or Foraig Country) MARYLAND		
Marylend H show	Pue Ma		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limit	
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Demit. Pages 1 and 2 should be file	und M	-	19a. Informant's Name/Relationship	WRIGHT (Type, Print)	19b.	Mailing Addre	ess (Straat			-		p Code) 20886	
	alth a		WALTER H. HERSHE	EY, HUSBAND				CHOICE					
	it of Healt if item 2 or other		20a. Method of Disposition 1 ☐ Buriai 2 ☐ Cremation 3	Demousl from State	20b. Piace of cematar)	Disposition (f	vama of	ce)	Date	20c. Location -	City or T	own, State	
	ment ment: lant: l		4 ☐ Donation 5 ☐ Other (Spe	cify)	METROP	ROPOLITAN CREMAT		IATORY	10/29/0	0/29/00 ALEXAND		DRIA, VA.	
ej amere	Department of Important: If I any injury or once.		21. Signature of Funarai Service Licensee Backer 22. Nama and Address of Facility MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 208										
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	hysician /Medicai xaminer		Immediate Cause (Final disease or condition resulting in death)		CANCER						1	Onset and Death 9 MONTHS	
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Tot	Tot	M	29b. Signature and title of certifier Aylesve h Hospite Physicia D005433						29d. Date signed (Month, Day, Year)				
			30. Name and address of person wh	o completed cause of dea	ath (Item 23a) (T	ype, Print)					1,6	000	
			Cheryl Ayleswort				ve.,	Washing	ton, D.	C. 2080)7		
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Sporks

State

Registrar

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State of Maryland / Department of Health and Mental Hygiene

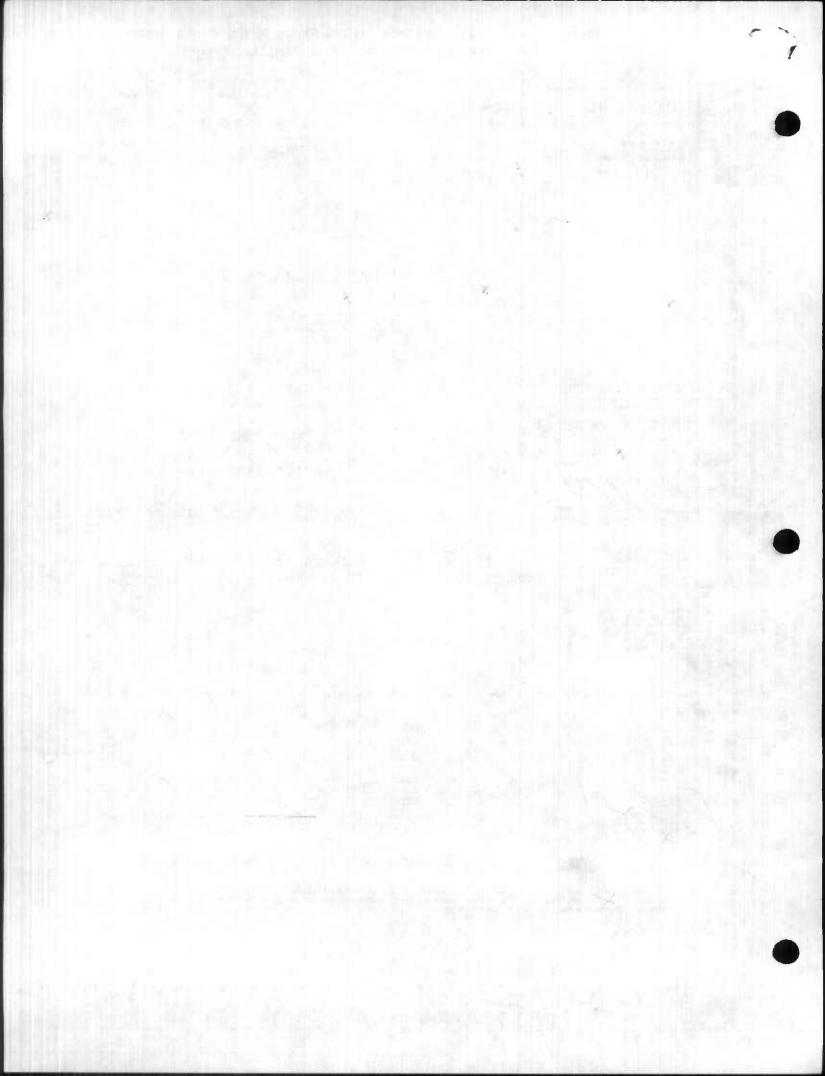
FCHD.KS 10/20 Certificate of Death Amended item#26 & 29 2. Date of Deeth 1, Decedent's Neme (First, Middle, Last) 3. Time of Death Month **Physician** 10:30pm HOOKER OCTOBER 2000 CATHERINE E. /Medical 4a Facility Name (II not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner FREDERICK FREDERICK SUNRISE ASSISTED LIVING If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) Birthplaca (Stata or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2 F Months Deys Yrs. 99 577-10-5003 Director JUNE 8 1901 WASH., Usual Rasidenca of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. insida City Limits 'natural', or Nema 23s or 28s-f show 1 Yes 20 No r than "natural", or hame 23s or 28s-f s the Medical Examiner must be notified Directo MD MONTGOMERY BEALLSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19131 JERUSALEM RD. 20839 U.S.A. Funeral 12. Was Dacedent Evar in U,S. Armed Forces? 1 Yas 2 No If Yes, Give Yaar or Datas: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - Amarican indian, Bleck, White, etc. 11. Marital Status 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: py WHITE 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within Elementery/Secondery (0-12) Collega (1-4or 5+) 12 ADMINISTRATIVE ASSISTANT ELECTRICAL UNION 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Mental Pages 1 and 2 should be merked JOHN E. DAVIS ALICE ELIZABETH ROBERTS ding. 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Department of Health a important: if item 27 is any injury or other trea page. ROBERT SCHULTZ/NEPHEW P.O. BOX 142, BEALLSVILLE, MD 20839 20b. Plece of Disposition (Nema of cematery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Steta 1 ☐ Buriel 2 Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) ENDERS/SHIRLEY F.H. 10/7 BERRYVILLE, VA 21. Signeture of Funeral September 22. Name end Address of Fecility HILTON FUNERAL HOME BOX 86, BARNESVILLE, MD 20838 Approximete Intervel Between Onsat end Daath 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart teilure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition rasulting in deeth) /Medical Examiner Due to (or as a consequenca of) Examiner The law requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immediata cause. Enter Undarlying Cause (Diseese or Injury that Initiated evants resulting in death) Last Bud Due to (or es a consequenca ot): ettending physicien for use as the buria Records, P.O. Box 68760. Physician/Medical Dua to (or as a consequence of): ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed by det P 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24e. Wes en autopsy performed? page 2 should Completed 1 Yes 1 Yes certificate Division of Vital or Attending Physicien: 25. Was case reterred to medical Be 26. Plece of Death (Check only one) Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yas 2 No 10 me 5□ Residence 6 ØOther (Specify)Assisted this 27. Manner of Deeth 28e. Deta of Injury (Month, Day Year) Injury at Work? 28d. Describe how injury occurred Certification: Living After 5 Pending investigation Injury after death.

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in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28t. Location (Street end Number or Rural Routa Number, City or Town, Stete) 28a. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D completely filled Hospital 1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, dete end placa, end due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end menner stated. edical 29a. Certifier 29d. Dete signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number October 20,2000 30. Nema and address of person who completed cause of feeth (Item 23a) (Type, Print) House Are, Frederick, md 21702 Shapito, m.O. 814 Toll 31. Dete tiled (Month, Dey, Year) 32. Registrer's Signeture State 1 0 2000 >

Registrar

DHMH 16 Rev 6/95

B. Spark **ORIGINAL**

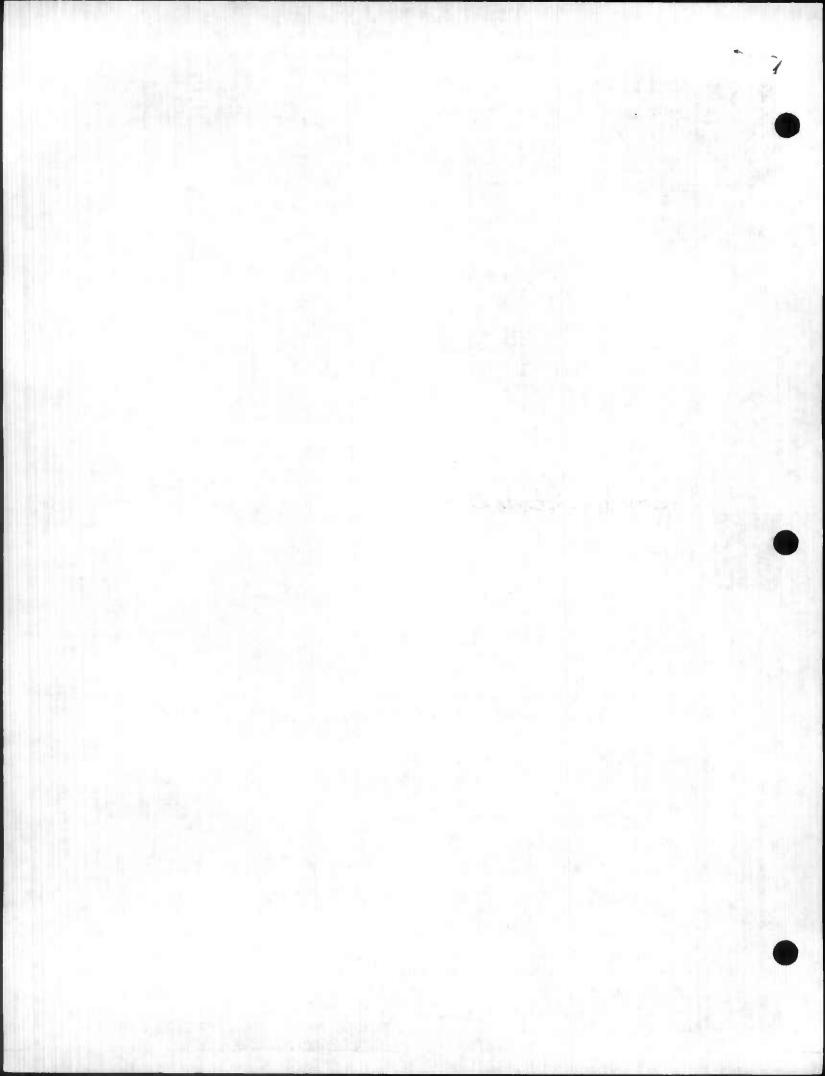


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death **Physician** October 15, 2000 12:30 P.M. Pauline Beatrice /Medical 4a Fecility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick 7. Aga (In yrs. last birthday) If Under 1 Yaer | If Under 24 Hrs. Birthplaca (State or Foreign Country) 5. Social Security Number 8. Dete of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 X F 86 Yrs. Aug 10, 1914 220-16-0639 Director Maryland Usuel Rasidanca of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 25s-f shor jens. r than "natural", or items 23a or 25a-f sho the Medical Examiner must be notified at Braddock Heights Maryland Frederick 1 ☐ Yas 2 No Directo 10f. Zip Coda 10e. Street and Number 10g. Citizen of What Country? 6012 Jefferson Blvd 21714 U.S.A. Funeral 14. Rece - American Indian, Black, Whita, atc. 12. Was Decedent Ever in U,S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puerto Rican, atc.) filed within 72 hours after 1 ☐ Yas 2 No If Yas, Giva 1 Naver Merriad 2 Married Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify Specify: White h 3X Widowed 4 □ Divorced Year or Datas Completed 15. Decedent's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) Tailoring Sewing Factory 18. Mothar's Nama (First, Middla, Maidan Surnama) 17. Father's Name (First, Middla, Last) should be nd Mental is marked Walter William . Tribby Dorothy Tritapoe 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19e. informant's Name/Ralationship (Type, Print) Pages 1 and 2 s ment of Health an Department of Health is Important: if item 27 is any injury or other tras 2058. Richard W. Hawker, Jr/Son 3901 Lander Road, Jefferson, Maryland 21755 Baltimore, 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, State 1 █ Buriai 2 ☐ Cramation 3 ☐ Ramoval from Stata St Paul's Cemetery Oct 19,2000 Jefferson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Addrass of Facility Keeney & Basford P.A. Funeral Home M00706 106 East Church St, Frederick, MD 21701 Part I. Enter the difease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or hear failure. List only one cause on each line. Approximate Intarval Batween Onsat and Death **Physician** /Medical Immediata Causa (Final diseasa or condition rasulting in daath) hyperosmolar diabetic coma hours Examiner Dua to (or as a consequence of) Examiner hours The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to Immediela cause. Entar Undarfying Cause (Disease or injury that initiated avants rasulting in death) Last Dua to (or as a consequenca of): and been signed by the attending physician should be detached for use as the buria P.O. Box 68760 Physician/Medical Dua to (or es e consequance of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown bleeding Gastrointestinal Division of Vital Records. Be Completed by 24b. Wara autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? Director: After this certificate has a in by the funeral director, page 2 1 Yas 2 No 1 □ Yas 2 □ No I or Attending Physician: after death. 25. Was casa referred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidanca 6 Othar (Specify) 1 Yas 2 No Medical Certification: To 27. Menne of Death 1 Natural 28d. Dascribe how injury occurred Injury at Work? 5 Panding invastigation Injury 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicida 6 Could not be datarmined To the Hospital or Atle within 24 hours after de To the Funeral Directo completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, deeth occurred at tha tima, data and placa, and dua to the cause(s) and mannar as stated.

2 Medical Examiner: On the best of examinetion and/or invastigation, in my opinion, deeth occurred at the tima, data and placa, and dua to the cause(s) and mannar stated. 29e. Cartifier 29d. Dete signad (Month, Day, Year) 29c. Licanse number 29b. Signature end titla of certifier D32073 Kathleen Wolern WS 30. Neme and addrass of person who complated causa of death (Itam 23a) (Type, Print) Brunswick, Md. 21716 Stern MO 610 Ninth ave

DHMH 16 Rev 6/95

State Registrar 2000 Segistrar's Signatura

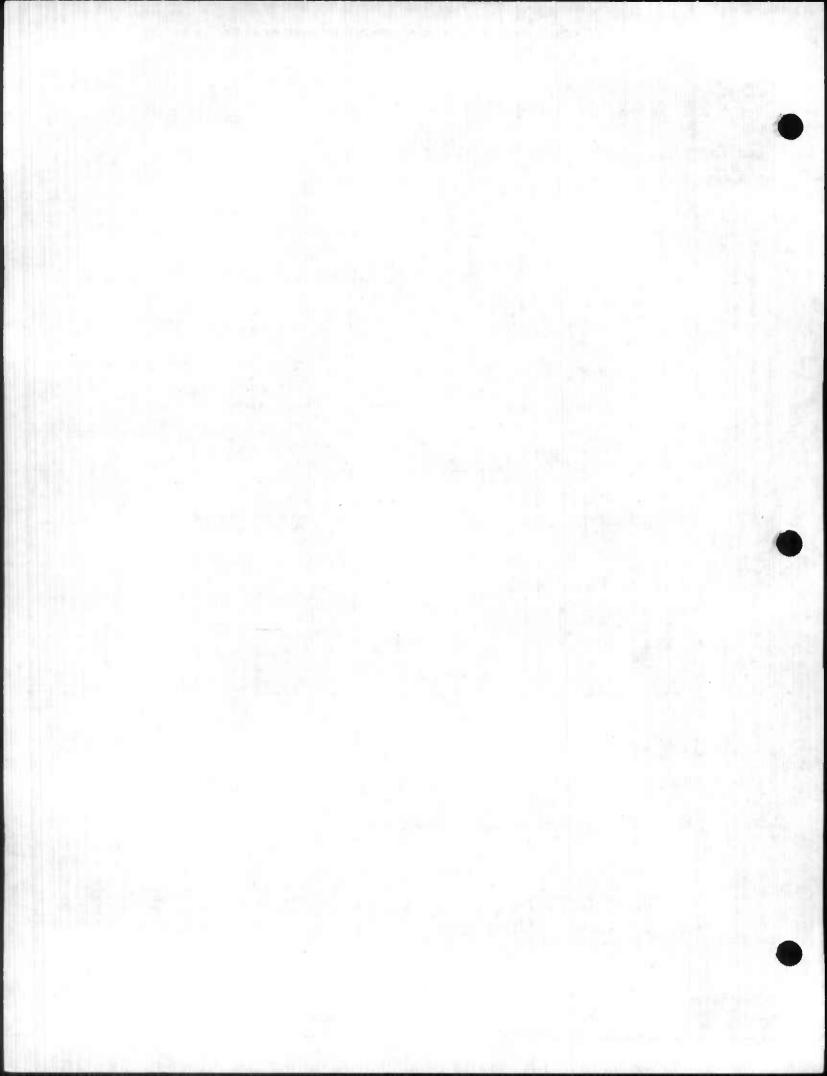


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day Year **Physician** ZILEEN HALL 1815 2000 10 30 /Medical Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner BAITIMORE BALTIMORS CITY Univ. OF MARYLAND MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Montha Daya Hours 1 M 2 X F 24 1949 Hawaii Director 342-42-6935 51 May Usual Residence of Deceden 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits must be notified at 1 ☐ Yas 2 No Directo Maryland Frederick Monrovia 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Home 23a 12507 Wolf Den Court 21770 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Rece - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) event, the Medical Examiner. Black, White, etc. 72 hours after 1 Never Merried 2 Married "natural", or Baltimore, Maryland 21215-0036 If Yes, Give Year or Detes: 1 Tyes 2 No Specify Specify. à 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within Hygieno. Wer than Elementary/Secondary (0-12) College (1-4or 5+) 12 Caregiver Self Employed 18 Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Be Pages 1 and 2 should be next of Health and Mental 1 Perry Hall Florence Patricia Donovan 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) Department of Health a Important: If Nen 27 is any injury or other tra-# Monrovia, Maryland 21770 Barbara Hall / Sister-in-law 12507 Wolf Den Court 20b. Place of Disposition (Name of cametery, cremetory or other place) Dete 20c. Location - City or Town, State 20a. Method of Disposition Noy 2000 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Removal from Stete 4 Donetion 5 Other (Specify) Hagerstown Crematory Hagerstown, Maryland 22. Name and Address of Facility of Europe Service Licensee Stauffer Funeral Homes, P.A. 8 E. Ridgeville Blvd. Mt. Airy, Maryland 21771 Approximate Interval Par 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. erval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical SQUAMOUS CELL wha Examiner Due to (or es e consequence of) Examine Sausmous CELL CERVICAL CANCER physician and s the burial-transit The law requires that the death certificate be asseuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es a consequenca of) for use as 60 ed by the a Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Ysa 2 No 3 Probably Unknown þ 24b. Wera sutopsy findings aveilable prior to completion of cause of death? should l Completed 24e. Wea en autopsy performed? has 9 2 95ed 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Physician: Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 Appatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yea ≥ No To this funeral 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28c. Injury at Work? After or Attending 5 Pending investigation Natural death. 1 Yes 2 No Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by 4 Homicide after 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated edical 2 Madical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner steted. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier 29c. License number 10/30/00 12437 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) 22 South GENERE ST. MD MICHAEL WINTERS MD BALTIMORE 31. Dete filed (Month, Day, Year) NOV 0 32. Registrer's Signetura State 2000

Registrar

DHMH 16 Rav 6/95

ORIGINAL



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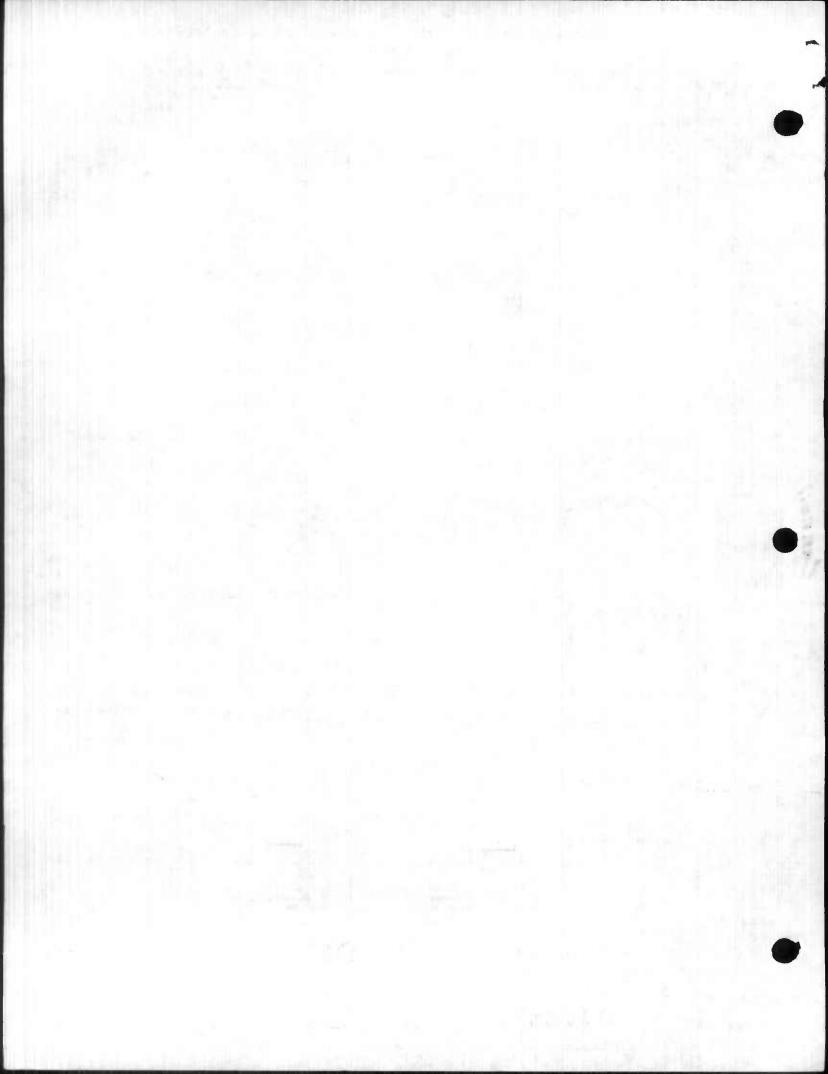
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Timothy O. Danel (M.) Ju; to 32 Peoples Plata Guscow De 19702 State 31. Date filed (Monith, Day, Year) 32. Registrar's Signature	ours ours filled		29e. Certifier 1 Certifying P	hvafcian: To the best of m	v knowledne de	eath occurred at the	time dete and place	end due to the d	euse/s) end me	enner as etc	ated
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State of Maryland / Department of Health and Mental Hygiene 11 3 6 1 9 1

	Amended	Item#28a,28c perVERBALO	G789 11/14/2000 EX	V Certificat	e of Death	B	ng. No.	00104
		1. Decedent's Name (First, Middle, La.	st)			2. Date of Deet	h	3. Tima of Death
	Physician	ROBERT LEE	HARRISON			OCTOBER -	26 2000	7.51 D.W
X	/Medical Examiner	4e Facility Name (If not institution, give			4b. City, Town, or I	ocation of Death	26, 2000 4c. County of Dea	7:51 P.M.
		Frederick Memori	lal Hospital		Frederi		Freder	ick
	Funeral Director	213-20-9787	Sex 7. Age (In yrs. 7. Age 7.	Months		8. Dete of Birth (Month, Dey, July 18	9. Bir C 2 1926 M	rthplace (State or Foreign ountry) aryland
	D B	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limits
	raho nda							1 ☐ Yes 2 ☑ No
-	a or 28a-f show be notified at Director	Maryland Carroll		Woodbine 10f. Zip	Code	1	Og. Citizen of Whet C	ountry?
	23a or ant be.	7257 John Picket	t Road		21797		United St	
-	r thems 23s iner.must	11. Meritel Status	12. Was Decedent Ever in U Armed Forces?	,S. 13. Was Dece	dent of Hispenic Origin? (S cify Cuben, Mexicen, Puert	pecify Yes or No-	14. Race - Am	ericen Indian,
21215-0020	Example Dy	1 Never Merried 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Yeer or Dates:	1 Yes		o Mican, etc.)	Bleck, Whi	White
5-6	oc within 72 ho ypans. we than "natural, it, the Medical.	15. Decedent's Ed (Specify only highest gra	ducetion ade completed)	16a. Decedent's Usua (Give kind of wo	el Occupation rk done during most of wor se retired)	king	16b. Kind of Business	s/Industry
121	mp Ide	Elementary/Secondary (0-12)	College (1-4or 5+)		se retired)		1.6	1
		12 17. Father's Neme (First, Middle, Last)		farmer	10. Mathada Mas	ne (First, Middle, A	self-emp	loyed
Maryland	Be see	Charles Edward				e Belle I		
7	To To	19e. Informent's Name/Reletionship (10h Maiting Address	(Street end Number or Ru			Zin Codel
Ma	17 th 0 2 th 10 th	Winifred Harrison	•		hn Pickett R			21797
e .	Tan I	20e. Method of Disposition		Pleca of Disposition (Ner cemetery, cremetory or o			20c. Location - City or	
altimore	tment of tant: If it qury or	1 ☑ Buriel 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specification)	y) P1	easant Ridg	e Cemetery	10/30/200	00 Woodbi	ne, MD
Bal	Depa impo any is	21. Signature of Funeral Service Licar	(over	Burri 1212	d Address of Fecility er-Queen Funday W. Old Liber	tv Road	Winfield.	A. MD 21784
	S tout	23a Part1 Enter the diseese, or com- mock or neert tailure. List only	plications that caused the deat one cause on each ling	h. Do not enter the mod	le of dying, such as cardiac	or respiretory error	est,	Approximate Interval Between
	hysician							Onset and Death
	/Medical Examiner	Immediate Cause (Finel disease or condition resulting in death)	· Carra	e ar	rest			SOMIN
	ē		Due to (d	or as a consequence of):		0 .		41.00
7	min min		b. Coror	rang	artery	dus	ose	TEHRS
68760,	physician and the burist-transit sthe burist-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events	Due to (d	or as a consequence of):				
68760,	physicia s the bur edical	Cause (Diseese or Injury that initiated events	C	r as a consequence of):				
	5 0 6	resulting in deeth) Last		as a somogeniso oi;				
Box	at me deam central by the attending eteched for use a Physician/M		d					
. 4	Sici	Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlying o	ause given in Pert I.	23b. Did 10	bacco use contribut	e to the cause of death?
Records, P.O	ed by the attendin deteched for use	24 stune	s. ocorti	aulu	W.	1 🗆 Y	98 2□No 3□F	Probably 4 Dunknown
ds,	2 2 2	Soymora			0		1 045	Manager de la company de la co
Oro	page 2 should Completed					24a. Was a perform		. Were eutopsy findings available prior to completion of cause
Records,	hes be 2 s				DIE LOR			of death?
						1 🗆 Ye	es 2 No	1 ☐ Yes 2 ☐ No
of Vital	s certificate has be director, page 2 s	25. Was case referred to medical axeminer?	Hospital:		Other:	eth (Check only on		
0	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1 Yes 2 No	28a. Date of Injury		DA 4 Nursing F		once 8 Other (Special own injury occurred	ecify)
00	After funer	1 Hafural 5 Panding investigation	(Month, Day Year)	Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No			
Division	effer death Director: A I in by the f ertificati	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	ome, farm, street, factor			reet and Number or F	Rurel Route Number,
ON S		4 Homicide	building, efc. (Specil	y)		City or Town	n, State)	
alcond.	Funer Funer Stely fill	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner steted.	wiedge, death occurred tion end/or investigation	at the time, date end place , in my opinion, death occu	, end due to the corred et the time, d	ouse(s) and manner e ate and place, end du	es stated. us to the cause(s)
100	within 7 to the comple	29b. Signeture and title of certifier	<u> </u>	296	c. License number	2	9d. Dete signed (Mon	nth, Day, Year)
	- > 0	Has 80	Capeula	4	DO06661	2	10/27	2/2000
		30. Name end eddress of person who	completed cause of deeth /Iten	23d) (Type Print)	Garth Rosent	era M D		, , , ,
		501 141 7	The ct.	Freder	ul INO	7 (7	10	
	State	31. Date filed (Month, Dey, Year)	32. Registrar's Signe	oture				
	Registrar	OCT 3 0 2	000 Seneva	9 1	na V			

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Data of Death 1 Decedent's Name (First Middle Last) 25 HAMILTON SHERWAN **JEWETT** 2000 6:00 a.m. Oct. 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Prince Georges Caring Touch Senior Care Ft. Washington | Hunder 1 Yaar | Hunder 24 Hrs. | 8. Data of | Months | Days | Hours | Min. | (Month, 6. Sex 1**X** M 2□ F Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Months Days Yrs. 88 140-10-7005 Oct. 13, 1912 Maryland Usuai Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 1 Yes 2 □ No Maryland Talbot St. Michaels 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 103 W. Marengo St. 21663 U.S.A. 14. Race - American Indian, 12. Was Decedant Evar in U,S. Armed Forces? 12) Yes 2 □ No WWIII If Yes, Give Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Maxican, Puerto Ricen, etc.) Biack, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: Black 3√2 Widowad 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) State of N.Y. Dept. of Labor Employment Interviewer 18. Mother's Neme (First, Middle, Maiden Sumama) 17. Fathar's Name (First, Middle, Last) James Jewett Lavinia Bailey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) Crescent Washington Granddaughter 2150 Alice Ave. Apt. 302 Oxen Hill, Md. 20745 20b. Plece of Disposition (Name of cemetery, cremetory or other place) Eastern Shore 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Nurial 2 Cremation 3 Removal from State 4 Donation 5 Othar (Specify) Maryland Veterans Cemetery Nov. 6, 2000 Hurlock, Md. Harrison E, Leonard Funeral Home 21. Signature of Funeral Service Licensee 312 S. Talbot St. St. Michaels, Maryland 21663 90. 23a. Part1. Enter the disease, or complications that ceused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) A171+eimes 6 um hu + m ting Due to (or as a consequence of) Due to (or as e consequence of): 23b. Did tobacco uss contributs to the causs of death? 1 Yss 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Director

Funeral

by

Completed

2

Funeral

Director

r than "natural", or items 23a or 26a-f show the Medical Examiner must be notified at

treumstic event.

permit. Pages 1 and 2 sh Depertment of Health and Important: If item 27 is m any injury or other treum pance.

the Marylend

death

2 should be filled within 72 hours after n and Mental Hygiena.

Saltimore, Maryland 21215-0020

Examiner physician and s the burial-trans Physician/Medical 88 use deteched à 8 Completed page 2 certificate has Be 10 this funeral Certification: After sftar death.

Division of Vital Records, P.O. Box 68760,

or Attending

- Hospital of 24 hours et

To the I within 2

certificate be

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were eutopsy findings available prior to 24e. Wes an autopsy performed? complation of causa of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medicei examiner? 26. Place of Death (Check only one) Other: Surring Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury at Work? Neturel 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No invastigation 6 Could not be determined 3 Suicide 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29a. Certifier (Check only one)

edical

1) **Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) end manner as steled.
2 **D Medical Examiner: On the bests of exeminetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D35 206 29d. Date signed (Month, Day, Year)

OCTUBER 30 200

30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print)

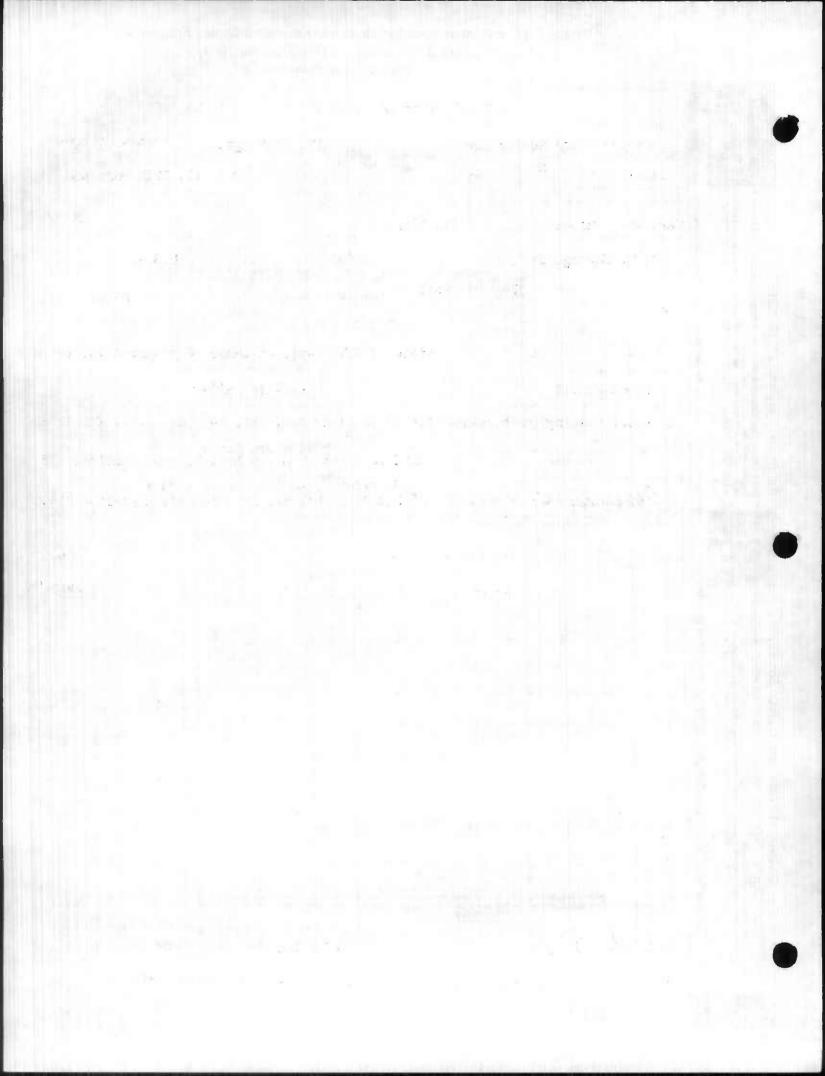
James

William To Towna my

11701 Leverythe Ro Ft. WAIN, Mo

State Registrar 31. Date filed (Month, Dey, Year) OCT 3 0 2000

32. Registrar's Signeture



State of Maryland / Department of Health and Mental Hygiene ()

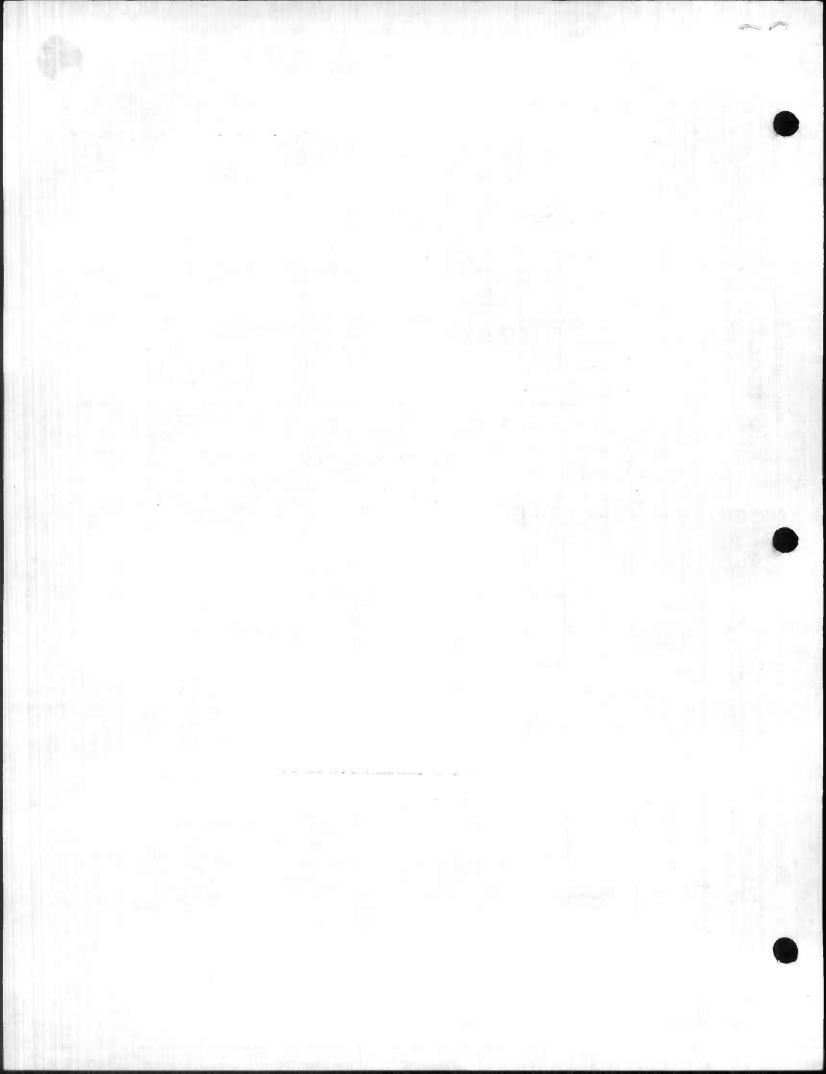
		1. Decedent's Nar	ne (First Midd	la (pei)				Certino	ate of	Dealli	2. Date of D	Reg. No.		3. Time of Death
Phys	ician				70	מונונר ב	ONT				Month	Day	Year	11:45 AM
	dical	4a Facility Nama	JERITE			OHNS(JN			4b. City, Town, or I	OCT.	30, 20		
Exam	niner		urban							Bethe		, , ,		MERY
Funer	al	5. Social Security		6. Sex			n yrs. last birtl		ndar 1 Year	If Under 24 Hrs.	8. Date of Bi	rth		
Directo	_	214-48- Usual Residence		101	M 2 🔭 F	7	3 Y	rs. Mon	ths Days	Hours Min.	Nov. 2	5,1926	Ma	placa (Stata or Foreign ntry) ryland
po au		10a. State	10b. County	,		10	c. City, Town	or Location					1	10d. Inside City Limits
n the Marylar r 25a-f show	oto	MD	Mon	ntgo	mery		Ga	ithe	sbur	g				1 Ves 2 □ No
or 28a-f	Director	10e. Street and N	umber					10f	Zip Code			10g. Citizan of		*
23 Page 4		101 0	denhal	l Av	enue				20	877		U	.S.A	•
020 urs after dea st', or items Examiner m	by Funeral	11. Marital Status 1 □ Nevar Mai 3 ☑ Widowed	rriad 2 Mar	ried	Armed For I Yes, Giryaar or I	orces?	r in U,S.			dispanic Orlgin? (S an, Mexican, Puart Specify:	pecify Yes or No o Rican, atc.)		ce - Americk, White,	
Baltimore, Maryland 21215-0020 semit. Pages 1 and 2 should be filed within 72 hours an Department of Health and Merkell Hyghen reportant; if them 27 is marked other than "natural", or any injury or other traumatic event, the Medical Exams	Completed	Elementery/Sec		nt's Educe est grade d		1-4or 5+)		(Giva kind o life. DO NO		pation during most of wor d)	king	16b. Kind of B		dustry
Page 1	00	12th						Domes	stic	40.14.4.4.1	455	Hom		
yland puld be fi Mental H mrked old	Be	17. Father's Name	.k Dove	200						18. Mother's Ner	en Dov		10/	
Ly day	2	19a. Informant's h			Print)		19h	Mailing Add	rass (Street				State. Zii	Code) 33060
A Ma		Glendo				ster				t 17th				
Tre, N		20a. Method of Di	sposition			2	20b. Place of cemerary	Disposition	(Name of	ca)	Date	20c. Location	City or To	own, State
More, more, pages 1 av content if them?			Cremation 5 Other (5		moval from		Linco				1/4/00	Rock	vill	e, MD
Baltin Baltin Departme mportant any injury	SUC#	21. Signature of 5	iuneral Service	Licensile	1/2		1.			ss of Facility N FUNER	AL HOM	E, P.A	•	
6- 4024			1ga	K-/	1 a	ow	ally	2	46 N.	Wash.	St., R	lockvil	le,	MD 20850
Physicia /Medica Examine	al	immediata Causa disease or condit	(Final	only one	cause on		ZP515		mode or dyn	ng, such as cardiad	, or respire cory t	arrost,	1	Approximate Interval Between Onset and Death
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Box Box attending for use a	No.			d										
B death	Sici	Part II. Other eign	ificant conditi	one contri	ibuting to d	leath but no	ot resulting In	the underly	ng cause giv	ven in Part I.	23b. Dio	tobacco uae co	ntribute 1	to the cause of death?
P. P. Chart the detach to detach	/ Phy										10	Y 00 2 ₺\No	3 Pro	obably 4 Unknown
Cords Po Box v requires that the death cent been signed by the attendin should be detached for use	Completed by Physician/M							54		7		s en autopsy formed?	an Co	Vere autopsy findings vallable prior to omplation of causa i deeth?
Re Re law he law	dmo										10	Yes 20No		□Yes 2ØNo
Vital II	BeC	25. Was case refe	erred to medica	ı						26. Place of Dea				2700 122,10
S condinect	ToB	examiner?		-	spital: 123	Inpatiant	2 ER/Out	patient 3E	DOA Oth	nor:		idence 6 Otl	ner (Speci	ify)
Sa Physic Pertitis	Ë	27. Manner of Dea	ath			of Injury			28c. Injur			how injury occur		
sior sior ath.	atio	1 Natural 2 Accident		igation	(IVIO)	nin, Day 10	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	M		Yes 2 □ No				
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Division of Vital Ramping to the Hospital or Attending Physician: The Inviting 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical Certification:	29e. Certifier (Check only one)			r: On the b		amination end			me, dete and place opinion, death occu				
To th withir To th comp	Z	29b. Signatura an	d tele of certific	1	1	301 (8)			29c. Licens			29d. Data signe	ed (Month	, Day, Year)
4			hun	V.	, be				A	51280	100	10-3	0-0	0
		30. Nama and add	iress of person	who com	pleted cau	se of deeth								
			iravar				- F F T T T T T T T T	3219	Exect	utive B	lvd.,	German	town	, MD 2087
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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 0 0 36187

					Ce	rtificate	of I	Death	7		Reg. No.		
	1. Decedent's Name	(First, Middle,	Last)				т			2. Date of D Month		Year	3. Time of Death
Physician /Medical	B	ARBARA	JOHN:	SON						OCT.	18, Dey	000	11.10 PM
Examiner	4a Facility Name (If						4	b. City, To	own, or L	ocation of Dea	th 4c. Cou	nty of Death	1
	Layhi	ll Cen	ter				S	Silve	er S	pring	Mo	ONTGO	MERY
Funeral	5. Social Security No		. Sex	7. Age (In y	rs. last birthday)	If Under 1		If Under	24 Hrs.	8. Date of Bi (Month, D	irth	9. Birth	nplace (State or Foreign
Director	578-76-	8047	1□M 2∏2F	44	Yrs.	Months	Days	Hours	Min.	Oct . 1	1,195	Ma	ryland
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A ST	10a. State	10b. County		10c.	City, Town or Lo	cation							10d. Inside City Limits
Mar Mar	MD	Montg	omery		Rocky	rille							Ves 2□No
or 28e-f s be notified	10a. Street and Nurr	ber				101. Zip C	ode				10g. Citizen	of What Cor	untry?
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har death y r thems 23s siner must	11. Marital Status		12. Was Dec	cedent Ever in	U.S. 13.	Was Decede	nt of H	ispanic Or	rigin? (Sc	pecify Yes or N	0- 14.1	Race - Amer	ican Indian,
The first of the control of the cont	12 Never Marrie	rd 2□ Marrier	Armed F	orces?		Yes, specify	Cuba	n, Mexica	n, Puerto	pecify Yes or No Rican, etc.)		Black, White	, etc.
21215-0020 d within 72 hours at years. The Medical Exam completed by F			If Yes, G	ive		1□ Yes 20	No	Specify	:		Spe	cify:	Black
Do not and Do		15. Decedent's		Duitou.	16a Dece	dent's Usual (Occup	ation			16b. Kind o	Rusiness/I	ndustry
1 21215-0 ed within 72 to	(Speci	fy only highest g	grade completed		(Give	kind of work DO NOT use	done o	durina mos	st of worl	king	TOO. TANG O	Dusinesari	ridustry
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timor thent of the tent if the	4 Donation			L	incoln	Park	Ce	em.	i]	10/23/	00 R	ockvi	lle, MD
THE STATE OF THE S	21. Signature of Fur	eral Service Lic	enseg /		/ 2	. Name and	Addres	ss of Facil	ity	T HOM	D D		
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	23a, Part1, Enter th	e distanse, or co	mplications that	caused the de	eath Do not ent	246	N .	Was	n . E	St., R	OCKV1.	rie,	MD 20850
Share a later	23a. Part1. Enter the shock, or hear	failure. List on	ly one cause on	each line.		0, 010 111000	J. 47	9, 000, 00	out dias	or roop notory			Approximete Intervel Between Onset and Death
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and I-tran	Sequentially list con	ditions,	•	Due to	(or as a consec	uence of):)	/		
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ontific													
			d										The state of
. 0 90 -	Part It. Other signific	cant conditions	contributing to d	death but not n	esulting in the u	nderlying cau	se giv	en in Part	I.	23b. Dio	I tobacco use	contribute	to the cause of death?
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										24a. Wa	s an autopsy	24b. V	Vere autopsy findings vailable prior to
() - 00 -										perl	omed?	0	valiable prior to completion of cause of death?
Re lew												9	. 1
= F # 8 0					dea in					10	Yes 200	2 1	☐ Yes 20 No
of Vital Physician: 1 This certifical director, p	25. Was case referre examiner?	ed to medical	Managan				Lou		e of Dea	th (Check only	one)		
F F F	1 Yes 2 1				☐ ER/Outpatier	t 3 DOA	Oth	400	ursing H	ome 5 Res	idence 6 🗆	Other (Spec	cify)
On O	27. Manner of Death	5 Pending	28a. Date (Mor	of Injury oth, Day Year)	28b. Time of Injury	280	. Injun	y at k?		28d. Describe	how injury oc	curred	
Attending or deeth. Sector: Attending by the fune	2 Accident	investigati	ion			М		Yes 2	No				
Division or Attending after deeth. Director: After d in by the fune	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not determine	be 28e. Place	e of Injury - At	home, farm, str	eet, factory, o	office				(Street and No	<i>mber</i> or Ru	ral Route Number,
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appropriate y filling	29a. Certifier	Cortifying F	hysician: To the	e best of my k	nowledge, death	occurred at	the tin	ne, date ar	nd place,	and due to the	cause(s) and	manner as	stated.
Ne Hospi n 24 hou Ne Funer pletsly fill edical	(Check only one)	2 Medical Ex	aminer: On the b	basis of exami nner stated.	nation and/or in	estigation, in	my o	pinion, dea	ath occur	red at the time	, date end pla	e, and due	to the cause(s)
DIVISIC To the Hospital or Attendamilio 24 hours after death or the Funeral Director: completely filled in by the Medical Certifical	29b. Signatura; and t	itle of certifier	Λ.		-	29c. l	icens	e number			29d. Date sig	ned (Month	, Day, Year)
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7									<u> </u>		04	211	2000
	30. Name and addre	ss of person wh	4 1	0 4	em 23a) (Type,	Print)	90	NO	1	- 3LVX	(1.	0- 2	wckulle
	JNA	IVIENC	lura	, , ,	2401	140).	U.	100	~ /·	30V/	, 500		TO MI
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Registrar	NC	N 0 2 2	000 1	permi	Ø.	apon	Rs						



Phys		Decedent's Name (First, Middle, I	oet)		Cel	rtificate o	Death	2. Date of Dea	Reg. No.	-	3. Time of Death	
	ician							Month	Dav	Year		
	dicai	Alice S. Johns					4b. City, Town, or	October		000	9:42 AM	
Exan	niner	4a. Facility Name (If not institution, g										
6		HCR Manor Care, 5. Social Security Number 6.			last birthday)	If Under 1 Yes	Chevy Ch ar If Under 24 Hrs	ase 8 Date of Birt	Monts	gomery 9 Birthols		
Funer Directo	_	229-60-9904 Usuai Residence of Decedent	1□м 2ДГ г	97	Yrs.	Months Day		8. Date of Birth (Month, Day Jan . 23	1903	Wash	ington, I	
yland M		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				10	d. Inside City Limits	
Man Man	to	Maryland Montgon	ery	Che	vy Cha	se					Yes 2□No	
th the	Directo	10e. Street and Number				10f. Zip Code			10g. Citizen of \	What Count	ry?	
th wi	<u>a</u>	8700 Jones Mill	Road			20815			United St		tes	
d within 72 hours after death with the Maryland plens. yiens. the natural', or liems 23s or 28s-f show the Monical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates:			Was Decedent of It Yes, specify Cu 1 ☐ Yes 2 ☐ N	f Hispanic Orlgin? (Suban, Mexican, Puerlo o <i>Specify</i> :	pecify Yes or No- o Rican, etc.)		ce - America ck, White, e v: Blac	tc.	
2 hou	P	15. Decedent'a	Educetion		16a. Deced	dent's Usual Occ	upation		16b. Kind of B	usiness/Indu	ustry	
hin 7	Completed	(Specify only highest g Elementary/Secondary (0-12)		5.1	(Give	kind of work don DO NOT use reti	e during most of wo.	rking				
filled with Hygiene other the	E O	Liomonary Coolinary (5 12)	College (1-4or 5+		Psy	chologis	st	D.C. Schools				
42 should be filed within 72 hours at a 22 should be filed within 72 hours at 12 marked other than "natural", or traumatic event, the Medical Examitral	Be	17. Father's Name (First, Middle, Las	(1)					ne (First, Middle,		ne)		
should be and Mentel marked o	2	William Stokes				Cassandra Beale						
2 should and Mer Is marke		19a. Informant's Name/Relationship				-		Number or Rural Route Number, City or Town, Sta ace, Detroit, MI 4820			-	
C = N .		Karlen S. Gaines	Daughte							3207		
Department of Hear mportant: if Itam in Injury or other		20a. Method of Disposition 1 Burial 2 Cremation 3				sition (Name of matory or other p						
t. Pa tman tant:		4 Donation 5 Other (Spec	<u> </u>	Ar.	0	n Nation		10/31/00				
permit. Pages Department of Important: If it any injury or or	DUCE.	21. Signature of Funeral Service	rinee	/	M	Mame and Add CGuire F	ress of Facility uneral Se	rvice, 1	inc.			
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Physicia /Medica Examine	ai	23a. Part1. Enter the disease, or co shock, or heart failure. List on immediate Cause (Finai disease or condition resulting in death)					lication	or respiratory ar	1031,		Approximate Interval Between Onset and Death .ess than month	
	a			Due to (o	r as a conseq	juence ot):						
be axecuted lcian and buriel-transit	Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury	b	Due to (o	r as a conseq	juence ot):						
death certificate be ax e ettending physician ed for use as the bunel	Medicai	Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or	r as a conseq	uence ot):						
eath cert ettendin	ciar											
ha d the	by Physician/Med	Part II. Other significant conditions Hypertension	contributing to death b	ut not resi	ulting in the u	nderlying ceuse (given in Part I.				the cause of death?	
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requiras that t		Non insulin dep	endent dia	bete	5			perior		of death?		
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The lev ate hes page 2	Completed	Hypothyroidism 25. Was cese referred to medical	endent dia	bete	5		26. Place of De		′es 2⊠No	of de	eath?	
sician: The lev certificate hes irector, page 2	o Be Completed	Hypothyroidism	Hospital:		ER/Outpatien	at 3□ DOA C		1 □ Y	res 2 🖔 No	of de	eath? Yes 20XNo	
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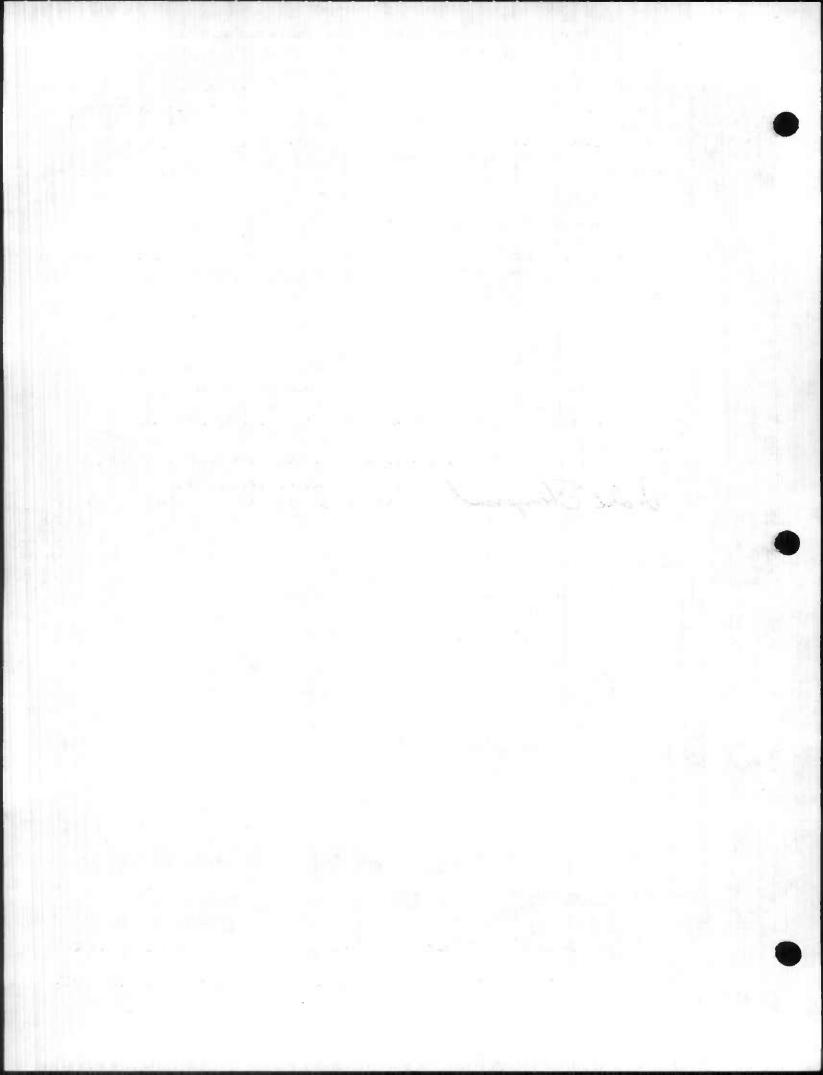
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Registrar

OCT 31 2000

32. Registrar's Signature

31. Date filed (Month, Day, Year)



Registrar

State

THEODORE M. KIN

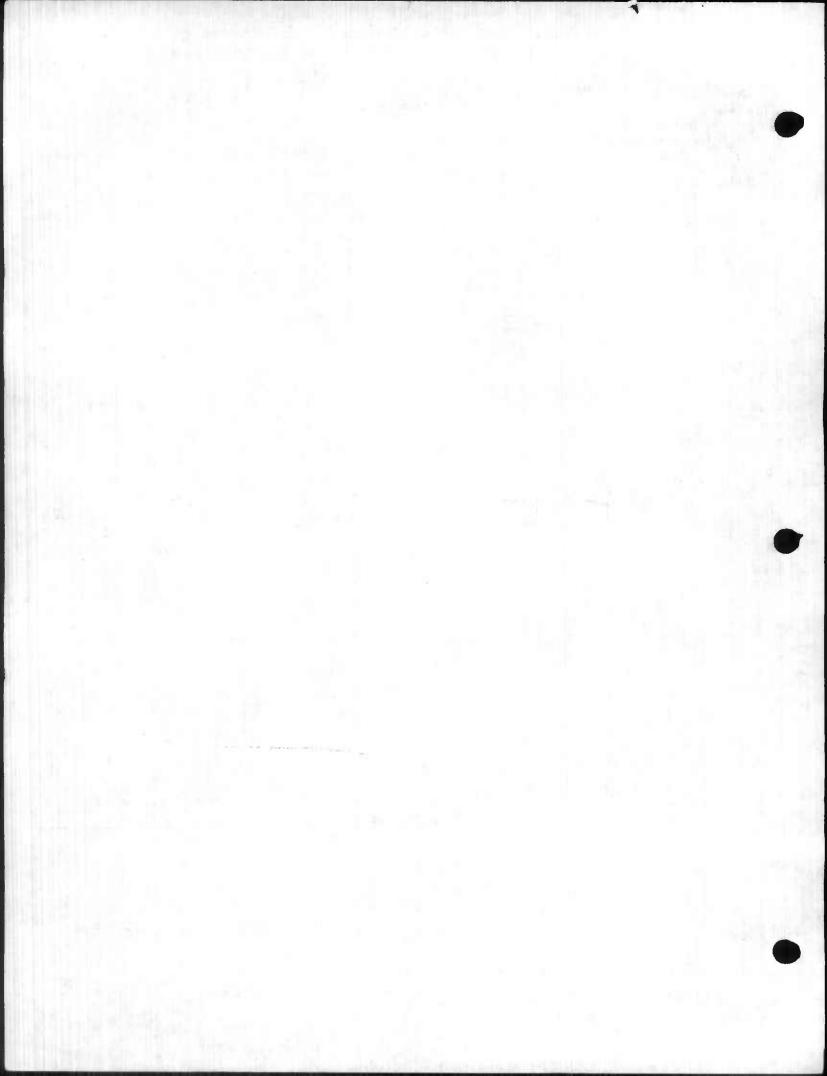
NOV 03

32. Registrar's Signature

Denena

2000

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item#20b perFHG789 11/14/2000 EW Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 515/PV1 2 ctober Thomas Dale Johnson 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death PelCAM P /// It Under 24 Hrs. / 8. Date of Birth Month, Day, Year Oct. 28, HARFORI ORIEN If Under 1 Ye 9. Birthplace (State or Foreign 5. Social Security Number . Age (In yrs. last birthday) Pennsylvania Days KXM 2 F Months 83 180-09-3984 10e. State 10c. City, Town or Location 10b. County 10d. Inside City Limits YYes 2 No Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 154 Bay Blvd. 21078 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 220No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Merried Specify: White 1 ☐ Yes 200No Specify: 3€Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dairy Manager Grocery 10 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Port Johnson Eva Ramsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Barbara S. Greenplate 108 Delaplane Ave., Newark, Delaware 19711 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Church of the Ascension Date Cemetery 10/27/00 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Street, Maryland 22. Name and Address of Facility Tarring—Cargo Funeral Home, P.A. 21. Signature of Funeral Service Licensee Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tntervat Between Immediate Cause (Final disease or condition resulting in death) Cancer wells Metastasy GM muss. Pan creation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? agliry 1 Yea 2 No 3 Probably 4 Unknown durance 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Examiner The law requires that the death certificate be executed the buriel-transit 980 or Attending Physicien: funeral director.

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Director: Aft
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To the Hospital o within 24 hours of To the Funerel D

completely

Box 68760,

P.O.

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Division

Physician

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Examiner

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1 and 2 should be Health and Mental

Pages

Physician

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Examiner

Physician/Medical þ Completed 25. Was case referred to medical examiner? Medical Certification: To Be 1 Yes 2 No 27. Manner of Death 5 Pending investigation 2 ☐ Accident

3 Suicide

4 ☐ Homicide

(Check only one)

Coronary

28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Whiam MD

6 Could not be

29c. License number 032609 29d. Date signed (Month, Day, Year) 10/24/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Karnyolin Mulyan

To noc Revelution st. Harre De Grace MD21078

State Registrar

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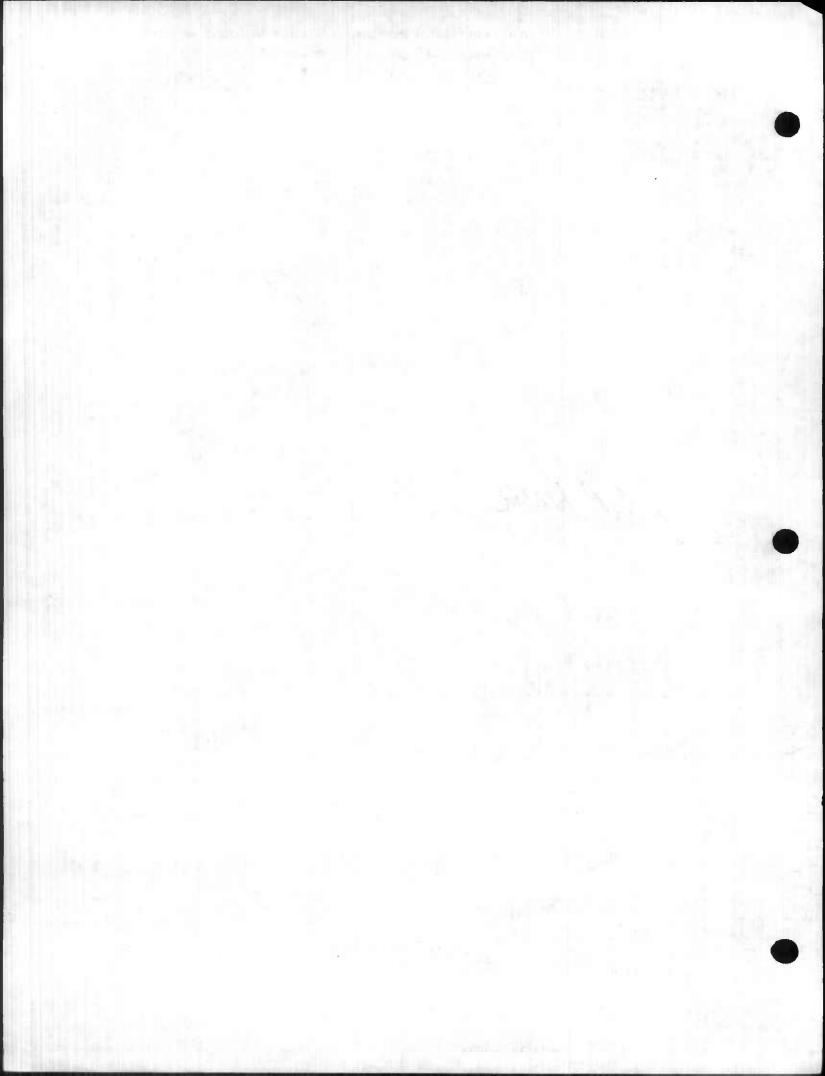
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State of Maryland / Department of Health and Mental Hygiene

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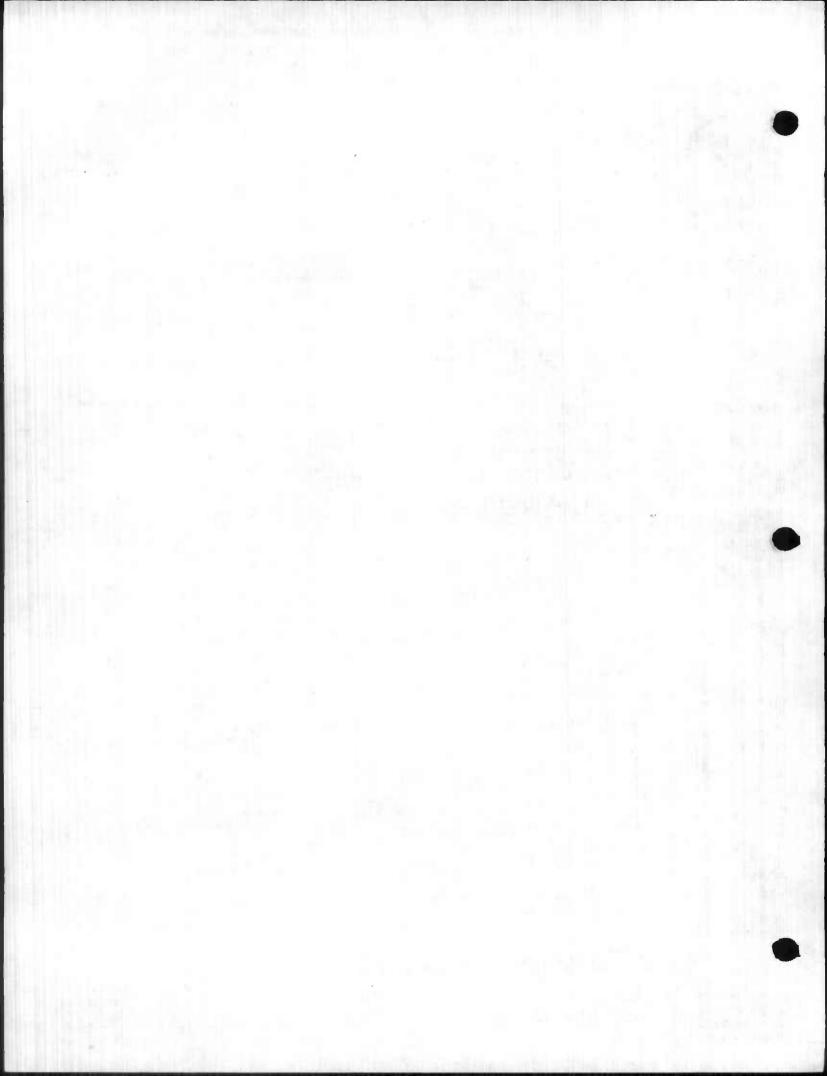
			Cer	tificate of	f Death		Reg. No.		00151
	1. Decedent's Name (First, Middle, Las	s1)				2. Dete of De Month	eth Day	Year	3. Time of Death
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Examine	An English him of the address of the	e street and number)			4b. City, Town, or	Location of Deat	4c. County	of Death	
	Suburban Hospita	al			Bethesda		Montg	gomer	У
Funeral	Social Security Number 6. Social Security Number	Du Me		If Under 1 Yes Months Day		(Month, Da	th y, Year)	9. Birthp	place (State or Foreign
Director	577-48-0835 Usual Residance of Decedent	87	Yrs.			Sept.21	, 1913	Rus	ssia
2 1.	10a. State 10b. County	10c. Ci	ty, Town or Loc	ation				1	Od. Insida City Limits
f sho	Md. Montgo	morry D	ockvill	0					1⊠ Yes 2 □ No
with the Marysi e or 28a-f sho be notified at	Md. Montgo	mery R	JCKVIII	10f. Zip Code			10g. Citizen of V	Whet Coun	itry?
23s or	11702 Magruder La	ne		20	852		U.S.A		
er death Berne 2 Dec mus	11. Maritel Status 1 Never Merried 2 Married	12. Was Decedent Ever in U	J,S. 13. W		Hispenic Origin? (Suben, Mexican, Puert	pecify Yes or No		a - Americ	
or he mines		Armed Forces? 1 Yes 2 No				o Hican, etc.)		k, White,	etc.
5-0020 72 hours after natural", or its dical Examina	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Detes:	1	☐Yes 2월N	o Specify:		Specify	<i>/:</i>	White
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altimore, Maryland 21215-0020 mil. Pages 1 and 2 should be filed within 72 hours an partment of Health and Mental Hygiene. portment of Health and Mental Hygiene. portment if from 27 is method other than "natural", or y injury or other traumatic event, the Medical Example.	20a. Method of Disposition 1⊠ Burlal 2 ☐ Cremation 3 ☐		cemetery, crem	sition (Name of atory or other p	lece)	Oct.31,	20c. Location -		
times part	4 □ Donation 5 □ Other (Specify			k Cemet		2000	Washing		D.C.
Salt Salt Salt Salt Salt Salt Salt Salt	21. Signature of Funegal Service Licen	9 111			ress of Facility D				
- 401.64	* Somt N	1100	22	22 Wisc	onsin AVe	., N.W.	wash. D	. C. Z	20007
	23a Part Enter the disease, or composite or heart faiture. List only	plicetions that caused the deel one cause on each line.	th. Do not ente	r the mode of d	ying, such as cardia	or respiretory e	rrest,		Approximate Intervel Between
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The state of the state of	The second second	· ·	or as a consequ					1	
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P.O. that the detached detached	Part II. Other significant conditions of	ontributing to death but not res	sulting in tha un	denying cause	given in Part I.		Yes 22 No		the cause of death?
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OZA sign						24a. Was	an autopsy	24b. W	ara autopsy findings
Par should binous	Decubitis Ulcer	r				репо	ormed?	CO	ailable prior to impletion of cause desth?
The lay						10	Yes 2⊠No		Yes 2□No
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Vision Attender description by the	3 Suicide 6 Could not be datarmined	28a. Place of Injury - At h	ome, farm, stre	et, factory, offic	a			er or Rura	al Route Number,
Direct Am	4 Homicide	building, etc. (Special	fy)			City or 10	wn, Stata)		
Hospital Puneral Runeral Itely filled	27. Mannar of Death 1 Naturat 2 Accident 3 Suicide 4 Homicide 29e. Cartifler (Check only one) 27. Mannar of Death 5 Pending Investigation 6 Could not be datamined	yalcian: To tha best of my kno	wiedga, daath	occurred at tha	tima, date and place	, and due to tha	causa(s) and me	annar as s	itated.
the Ho hin 24 I	(Check only 2 Medicat Exam	niner: On the basis of examina and manner stated.	ation and/or inv	estigation, In my	opinton, daath occu	irred at the tima,	data and placa,	and due to	o tha causa(s)
	29b. Signature and title of cartifier	0 -10	1	29c. Lice	nse number		29d. Date signe	d (Month,	Day, Year)
	Sole	COTAN	m	11	921		October	28,	2000
5	30. Name and address of person who o	completed cause of death (Iter	m 23a) (Type, F						
	John D. Galotto,				Rockville	,Marylan	nd 20852		
Stat	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	1					
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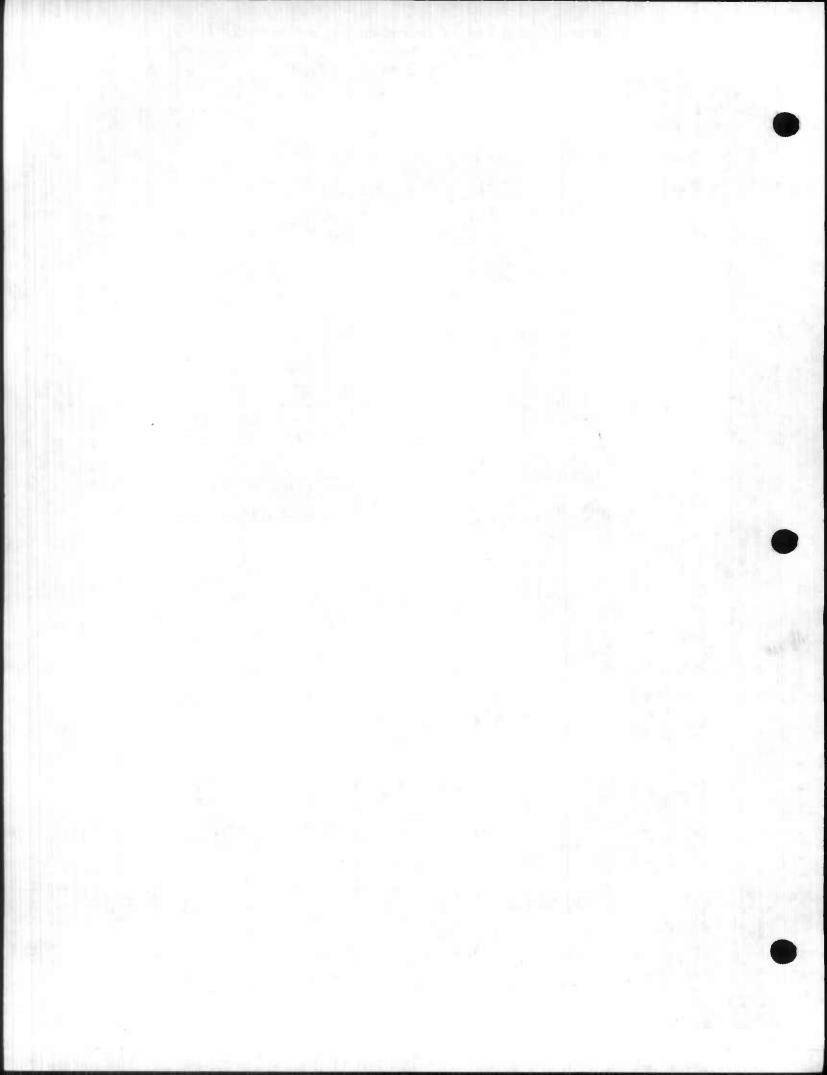
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State of Maryland / Department of Health and Mental Hygiene 0 36 | 92

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			15. Decedent's E	ducation	-	16a Dec	cedent's U	sual Occi	pation			16b. Kind of Br	usiness/Ind	lustry
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	198	. Informant's Nan	ne/Relationship (Type, Print)		19b. Ma	iling Addre	ess (Stree	at and Number	er or Rura	al Route Numbe	r, City or Town,	State, Zip	Code)
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Examiner	Sec	uentially list cond ny, leading to imm se. Enter Underl use (Disease or In	ditions,		Due to (or as a cons	sequence o	of):						
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Physician/M											10)	(aa 2 🔯 Ma	3 Prob	bebly 4 Un
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Ö		S/P	Pneumoni	.a							1 U Y	es 2 No	1 🗆	Yes 2□ No
Be	25. 1	Was case referre	d to medical						26. Place	of Death	(Check only or	ne)		
0		examiner? 1 ☐ Yes 2]() N	0	Hospital: 1 ☐ Inpo	atient 2	ER/Outpat	ient 3	DOA O	ther: 40X Nu	rsina Ha	me 5 Resid	ence 6 DOth	er (Specifi	v)
Ξ.		Manner of Death		28a. Date of I (Month,		28b. Tima	1000	28c. Inju			28d. Describe h			,
5	1	Natural	5 Pending investigatio		Day Year)	Injun	M		ork? ∃Yes 2 🔲 i	No				
Certification:		2 Accident 3 Suicide	6 ☐ Could not b	e one place of	Inium. At h						20f Loantion /C	Yeart and Shumb	har as Burn	I Doute Alumba
ŧ		4 Homicide	determined	200. Placa Of	etc. (Speci	fy)	street, tact	огу, опнов	•	1	28f. Location (S City or Tow		ier or murai	i rioute Numbei
Ca	29a	Certifier 1 (Check only 2	Certifying Ph	ysician: To the be	st of my kno	owledge, de	ath occurre	ed at the t	ime, date an	d place, a	and due to the d	ause(s) and ma	anner as st	ated.
edical		one)	☐ Medical Exal	and manner	stated.	ation and/or	mvestigati	on, in my	opinion, dea	in occurr	ed at the time, t	late and place,	and dua to	tne cause(s)
Z		Signeture and tit	le of certifier	1/0		.4 .		29c. Licen	se number		2	29d. Date signe	d (Month, I	Day, Year)
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-	M: #26 PER	Nama (First. M	liddle. Las							2. Date of		•0.		3. Time of Death
sician		H KEMP								Month	C	Day 28 9	Year	0914
edical miner	4a Facility Nan		ution, giv	a street and n	umber)			4b	c. City, Town, o	Location of D	eath 4	4c. County		0 1. 1
IIIICI	ST. AG	NES HOS	PITA	L					BALTI	MORE				
	5. Social Secur 300-61-		6. S	ex □M 2ÅF		In yrs. last birthd Yrs	Months Da	ear ays	If Under 24 Hi Hours Mi		Day, Yea	1910	9. Birthple Count VA	ace (State or Foreigny)
	Usual Resident 10a. State	ce of Deceden 10b. Cou			1	Oc. City, Town or	Location						10	Od. Inside City Limit
ctor	MD					Bal	timore							tX Yes 2□N
I Director	10e. Street and						10f. Zip Cod				10g. C	Citizen of W	Vhat Count	ry?
Funeral	10 Tuj	rk Gart	h	12. Was De	cedent Eva	ar in U,S. 1	3. Was Decedent	of His	spanic Origin?	Specify Yas or	No-		JSA e Amarica	
by Fur	7.7	Married 2 1		Armed F 1 Yas If Yes, G Year or	2 ♣ No Give		If Yas, specify (Specify:	irto Rican, etc.)			k, Whita, e Whit	
	1	15. Dece Specify only his	dent's Ed	lucation	-/)	16a. De	ecedent's Usual Oc	ccupat	tion	orking unk	16b.	Kind of Bu	siness/Ind	uetry unk
Be Completed		Secondary (0-1	12)		(1-4or 5+)	iii	ive kind of work do e. DO NOT use re	etired)	arang most or H	orking				
300	17. Father's Na	me (First, Mid	dle, Last)						18. Mother's N	ame (First, Mic	dle, Meide	en <i>Sum</i> em	е)	
Lo	Colema	in G. Po	erry						Suzie	R. Snyd	er			
	19a. Informant						eiling Address <i>(St</i>) Turk Ga					y or Town, 21228		Code)
		Disposition 2 Cremati			n State	20b. Place of Di cemetery, o	sposition (Name of crematory or other	of r place	9)	Date	20c.	Location -	City or Tox	wn, State
	21. Signatura				100000000000000000000000000000000000000	ctor	22. Name and Ad State An	ddrass	s of Facility Dmy Boa	rd 655	W.]	Balti	more	Street
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dical Examiner	Immediate Cau disease or con resulting in dec	se (Final dition ath) st conditions, to immediate Underlying so or injury vents	a, of com	plications that one cause on	caused the each line.	scler	Baltimor enter the mode of LLL isequenca of):	dying	, such as card	ac or respirato		Otsea	Je	Onset and Death
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 2. Date of Death 1. Decedent's Nama (First, Middle, Last) Month **Physician** 11:45 PM 2000 Joseph Frank Kennedy Oct. /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Nama (If not institution, giva street and number) **Examiner** Mariner Health Care at Circle Manor Montgomery Kensington If Under 1 Year | If Undar 24 Hrs. Date of Birth (Month, Dey, Year) Dec 6, 19 Birthplace (State or Foreign Country)
 MD 5. Sociel Security Number 7. Aga (In yrs. last birthday) **Funeral** Hours 10M 20 F 86 Yrs. 216-44-9516 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limita 10a. Stete 10b. County "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yas 2 No MD Montgomery Kensington Directo 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 10303 Montgomery Ave. 20895 Funeral 14. Rece - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yas 2 ☐ No
If Yes, Give Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 11. Merital Stetus filed within 72 hours after 1 Never Merried 2 Married Maryland 21215-0020 1 ☐ Yes 2 ☐ No by Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupetion (Giva kind of work done during most of working life. DO NOT usa retired) 15. Decedant's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Government Elamentary/Secondary (0-12) College (1-4or 5+) Post Office Supervisor 18. Mothar's Name (First, Middle, Maiden Sumama) 17. Fethar's Nema (First, Middle, Last) Be should be in and Mental is marked George Fred Kennedy Mary Elizabeth England 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Routa Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum once. Lorraine Kennedy /Wife 10303 Montgomery Ave., Kensington, MD 20895 Baltimore, 20e. Method of Disposition
1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State 20b. Plece of Disposition (Neme of cematary, cremetory or other plece) Nov 1 20c. Location - City or Town, Stata Beltsville, MD Chesapeake Crematory 2000 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funaral Service License 22. Name and Address of Facility
Rapp Funeral & Cremation Services 933 Gist Avenue Silver Spring, MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrast, shock, or hear failure. List only one cause on each line. Approximata Interval Batwe Onset end Deeth **Physician** /Medical Immediate Causa (Finel disease or condition resulting in deeth) Aspiration Pneumonia 1 month **Examiner** Dua to (or as a consequence of) Examiner Parkinson's Disease The law requires that the death certificate be executed ed by the attending physician and detached for use as the bunal-trans Sequentially list conditions, if any, leeding to immediata cause. Enter Underlying Cause (Disease or injury that initiated avents rasulting in death) Last Dua to (or as a consequence of) Box 68760, Physician/Medical Due to (or es e consequence of) P.O. 1 Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? been signed by I should be detact 1 Yaa 2 No 3 Probably 4 Unknown Dementia Division of Vital Records. þ 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? page 2 should Completed certificate has 1 Yas 2 No 1 Yes 2 No or Attending Physician: Be 25. Wes case rafarred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To this 27. Menner of Death 28b. Tima of 28d. Describe how injury occurred After s after dea... ai Director: Aftr 1 Délatural 5 Pending investigation 1 Yes 2 No 2 Accidant 6 Could not be datarmined 3 Suicide 28f. Location (Street end Numbar or Rural Route Number, City or Town, Stata) 28e. Plece of Injury - At home, ferm, street, factory, office building, atc. (Specify) filled in by 4 Homicida within 24 hours a Hospital 1 Pcertifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and dua to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and menner stated. 29a Cartifier edicai To the 29c. License number 29d Date signed (Month, Day, Year) 29b. Signeture and title of pertifier D00053528 October 31, 2000 CO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daphna Henkin M.D. 2309 Shorefield Rd., Wheaton, MD 20902 31. Date filed (Month, Dey, Year)

DHMH 16 Rev 6/95

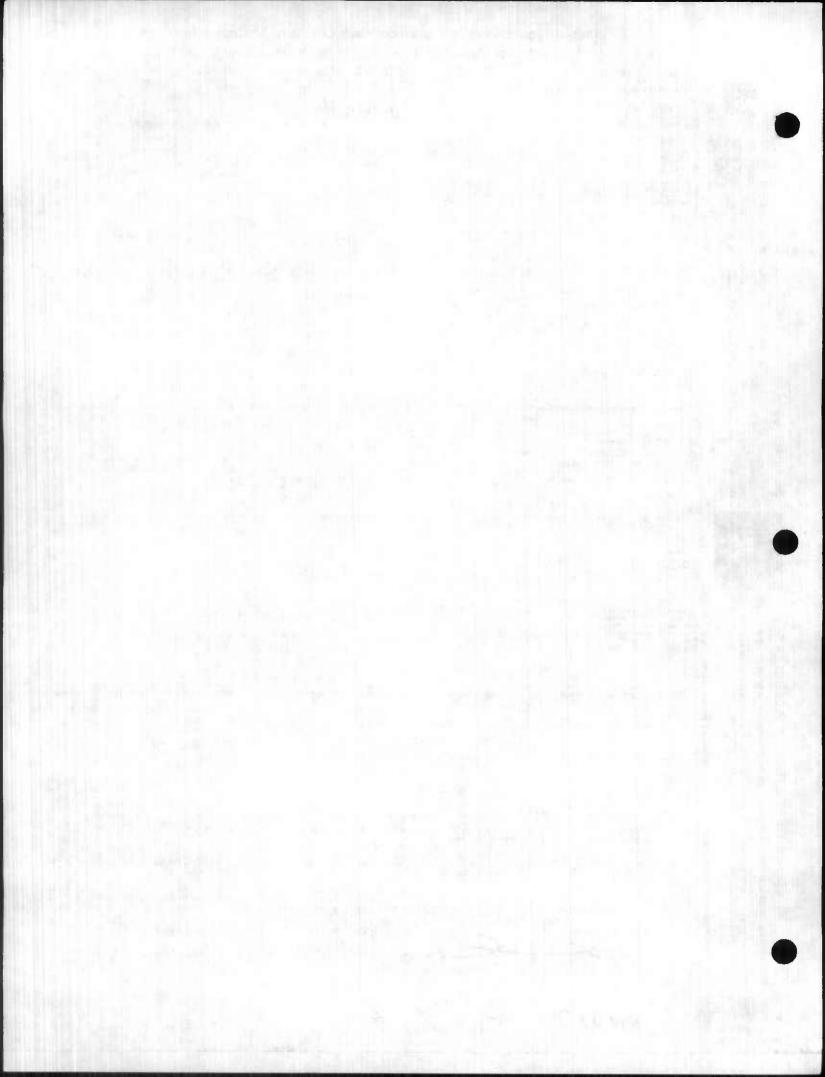
State

Registrar

NOV 03

2000

32 Registrer's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Marvin Richard Kidwell October 26, 2000 8:48P. 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death 8402 57th Avenue Berwyn Heights Prince George's 5. Social Security Number If Under 1 Yaar If Under 24 Hrs. 8. Deta of Birth (Month, Day, Year) July18, 1940 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) Days Months Hours 15 M 2□ F 212-36-7218 60 Yrs. Washington, D.C. Usuel Rasidance of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits Yas 2□No Maryland Prince George's Berwyn Heights

flams 23a 0 'natural' Pages 1 and 2 should be filed within h and Mental Health Item 27

Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

Funeral

Director

must be notified at

The Maryl

Physician

/Medical Examiner

The law requires that the death certificate be executed attending physician end for use as the burial-tran Division of Vital Records, P.O. Box 68760, signed by the a been sig page 2 s After this certificate has funeral director, page 2 To the Hospital or Attending Physician: Director: J within 24 hours a To the Funeral C

Be

To

Certification:

edicai

Ş	Maryland Prince G	eorge's	Berw	yn He	ights				X	as 2∐No
irec	10e. Street and Number				10f. Zip Code	T		10g. Citizen of V	What Country?	
aio	8402 57th Avenu	e			207	40		United	States	
by Funeral Directo	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent E Armed Forces? 1 Yas 2 YN If Yas, Giva Yaar or Datas:	1122	ft.	as Decedent of Hi Yas, specify Cubar	spanic Origin? (Sp n, Maxican, Puerto Specify:	pecify Yas or No- o Rican, atc.)		e - American Indian, ck, Whita, atc. White	
eted	15. Decedent's Ed (Specify only highast grad	ucation da complated)	1	6a. Decede	ent's Usual Occupa ind of work dona d O NOT usa ratired,	ition luring most of work	king	16b. Kind of Bu	usinass/industry	
dwo	Elementary/Secondary (0-12)	Collega (1-4or 5-	+)	Builde				Kidwell 8	Kidwell,	Inc.
To Be Completed	17. Father's Name (First, Middle, Last) Dellburt A. Kidwe	11, Sr.				18. Mothar's Nem Esther			na)	
	19a. Interment's Name/Ralationship (7	ype, Print)		19b. Melling	Addrass (Street a	and Number or Ru	ral Routa Numbe	er, City or Town,	Stata, Zip Code)	
	Jeane Kidwell (wi	fe)		same a	as #10					
	20a. Mathod of Disposition 1 Burial 2 Cramation 3 4 Donetion 5 Other (Specify		cem	etary, crema	ition (Nama of atory or other place shington		Data y 10/30/		City or Town, Stata	
	21. Signature of Funeral Sarvice Licens Matthew A	-Brown	7	Doi 440	Name and Addras naid V. 1 00 Powde:	Borgward r Mill Re	t Funera d. Belts	l Home, sville,	P.A. Maryland	20705
	23a. Part f. Enter tha disease, or comp shock, or haart teilura. List only o	ona ceusa on aach lin	a.				or raspiratory er	rrest,	Approxin Intarval I Onsat ar	Batween nd Death
	diseese or condition rasulting in daath)	8.		N 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Infarct:	ion			Sudd	den
ner			Dua to (or as		nanca ot): D i sease					
Exam	Sequantially list conditions, if eny, laading to immediata cause. Enter Undarlying Cause (Disaase or injury		Dua to (or as	s a consequ	ance of):					
Completed by Physician/Medical Examiner	that initiated avants rasulting in death) Last	d	Oua to (or as	a consequi	ance of):					
ysiciar	Part II. Other afgniffcant conditions co	ontributing to death bu	it not resultin	ng In tha und	derlying cause give	an in Part f.			ntributa to the cau	
A							10	Yaa 2 No	3 Probably 4	X Unknow
leted by					- 150-			en autopsy rmed?	24b. Wara autopi available pri completion of death?	or to
Comp							10	Yas 2X No	1 ☐ Yes 2	2□ No

State Registrar

31. Data tiled (Month, Day, Year)

29b. Signeture and title of certifier

25. Wes case retarred to medical examiner?

1X Yas 2 No

27. Mannar of Death

1X Natural

2 Accidant

4 | Homicida

3 Suicide

29a. Cartifier

Hospital:

28a. Dete of Injury (Month, Day Year)

30

5 Panding investigation

6 Could not be detarmined

32, Registrar's Signatura

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Place of Injury - At homa, tarm, streat, factory, office building, etc. (Specify)

28b. Tima ot

30. Nama and address of person who completed cause of death (Itam 23a) (Type, Print)

K. Joseph Mathew, M.D. 6510 Kenilworth Avenue, # 1400 Riverdale, Maryland 20737

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated.

29c. Licansa number

1 Yas 2 No

26. Placa of Death (Check only ona)

Other: 4 Nursing Homa 5 Rasidence 8 Other (Specify)

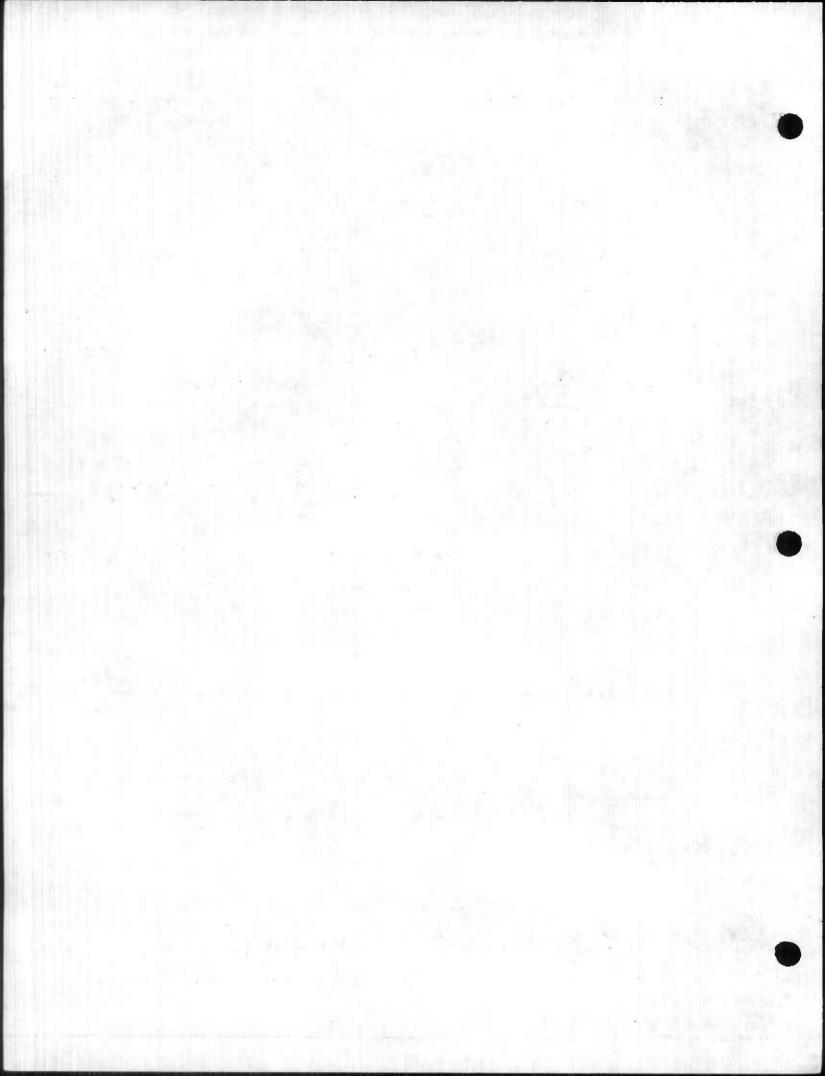
28d. Describe how injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29d. Data signed (Month, Day, Year)

October 27, 2000

20



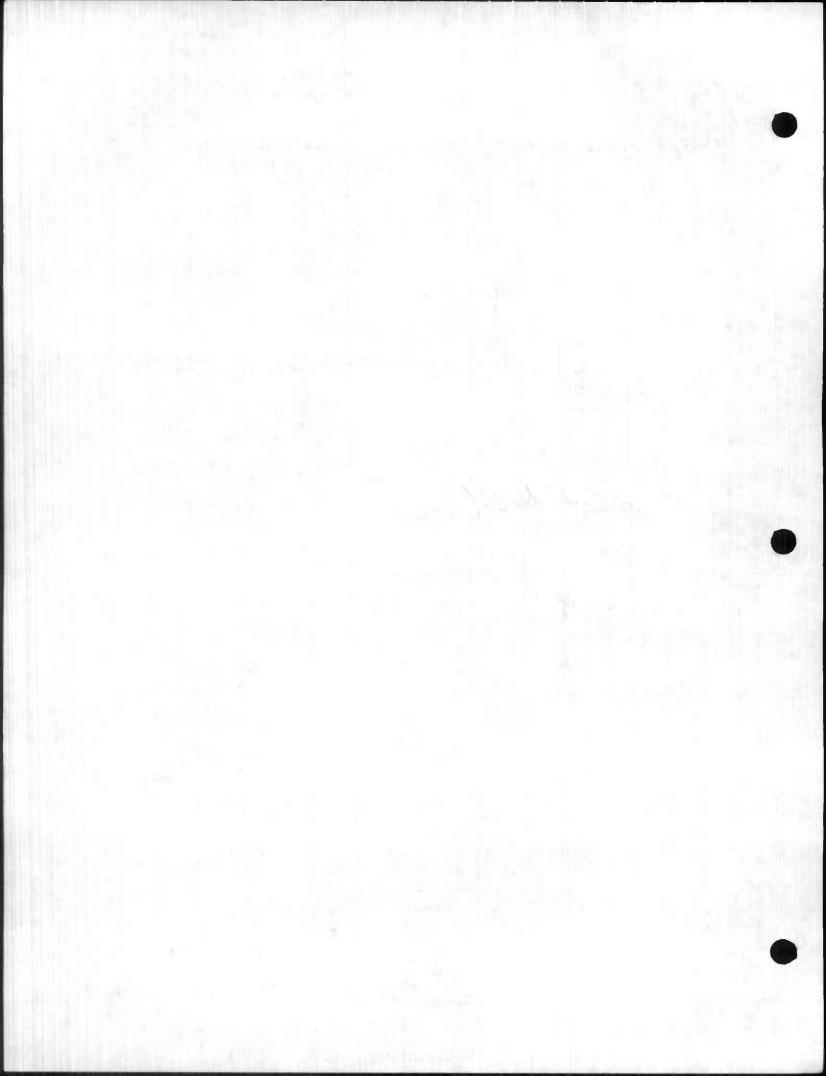
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent'a Nema (First, Middle, Last) Month **Physician** 9:26 AM October 25th 2000 nomas /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not institution, give street and number) Examiner HOPKINS HOSPITAL ALT | MOLE
If Under 24 Hrs. | 8 CITY THE JOHNS if Under 1 Year B. Dete of Birth Month, Dey, Year) June 4, 1921 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** 1₺M 2□F Months Deys 79 Yrs. 723-16-9730 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 23a or 28a-f show ust be notified at Alexandria 1 Nes 2 No Va. n/a Director 10e. Sfreet and Number 10f. Zip Code 10g. Citizen of What Country? USA Examiner must be 22314 1250 S. Washington St. #621 12. Wes Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No 1943 -If Yes, Give Year or Detes: 14. Race - Amarican Indien, Bleck, White, etc. natural, or flams Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, atc.) 11. Marital Status after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify. Specify: white þ 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Cance Po Kerseatrech College (1-4or 5+) 5+ Elementary/Secondery (0-12) Cancer Research Scientist 17. Father's Nama (First, Middle, Last) 18 Mother's Neme (First, Middle, Maiden Surnama) Pages 1 and 2 should be and Mental marked Sarah Donovan Thomas Joseph King 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) artmant of Health an ortant: If Item 27 is 1250 S. Washington St., #621, Alexandria, Va. 22314 Hannah May L. King/wife 20b. Place of Disposition (Nama of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State St. Mary's Cemetery Oct.30,00 Alexandria, Va. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility
DeVol Funeral Home 2222 Wisconsin Ave., N.W., Washington, DC 20007 the the disease, or complications that caused the death. Do not entar tha mode of dying, such as cardiac or respiratory arrest, or heart feiture. List only one cause on each line. **Physician** /Medical Immediete Cause (Finel cholangiocarcir diseese or condition resulting in death) Examiner Due to (or as e consequence of): Examiner physician and s the burief-tran Sequentially fist conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initialed events resulting in death) Last Due to (or es a consequence of): Box 68760 Physician/Medicai Dua to (or as a consaguanca of) the the attending P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the causa of death? 2 X No 3 Probably 4 Unknown 1 Yaa signed by ě Division of Vital Records, by 24b. Were eutopsy findings available prior to complation of cause of death? 24a. Was en eutopsy performed? Completed page 2 No No 1 ☐ Yes 2 No 1 Tes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cardifica completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 28. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28c. Injury et Work? 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, State) 3 Suicide 6 Could not be 4 ☐ Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or invastigation, in my opinion, deeth occurred at the time, date end plece, and due to the ceuse(s) and menner steled. 29e. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) HOPKIUS HOSPITAL GOON, WOLF ST. BALTO, M.D. Hill Rebecca MD JUHNS 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State 2000 NOV 01

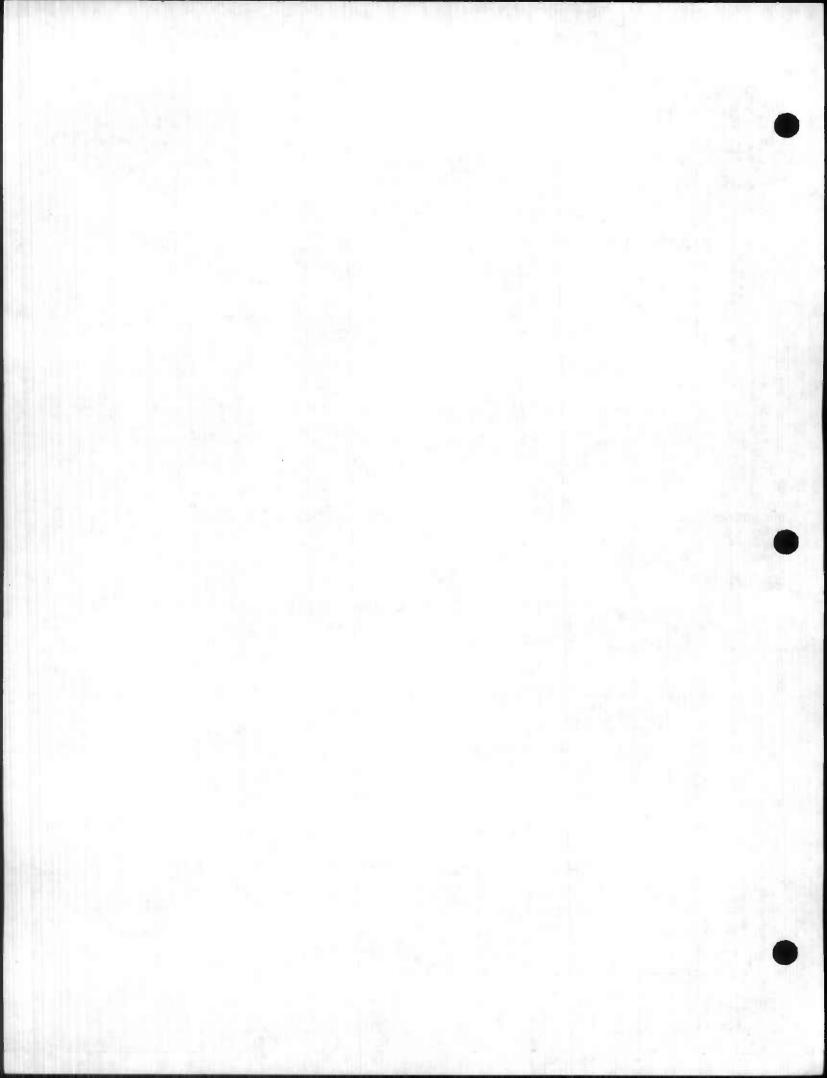
DHMH 16 Rav 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene 00 36197

			Ce	ertificat	e of	Death			Reg. No.		
	1. Decedent's Name (First, Middla, L	ast)						2. Data of De	eeth	MILE	3. Time of Death
hysician	Lillie Stalnaker	Kopsitz						Month	r 29, 20	Yaar)()()	10:20 an
/Medical Examiner	4a Facility Nama (If not institution, g					4b. City, To		cation of Deal			10.10 0.
xammer	Woodside Center					Silve	r Cn	ring	Montg	Omor	37
		Sax - 7. Age (In	yrs. lest birthday	/ If Under	1 Yaar	If Undar	24 Hrs.	8. Data of Bi			
neral ector	264-22-8218 Usuaf Rasidanca of Decedant	10 M 2 F	75 Yrs.	Months	Days	Hours	Min.	Jan 3	rth av, Year) 1, 1925	Geor	place (State or Fore ntry) gia
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riner must be notified at	Maryland Montgom		ilver S _I								1 □ Yas 2 🛣
in e	10e. Street and Number			10f. Zip	Coda				10g. Citizan of V	Vhat Coul	ntry?
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Funeral	11. Maritet Status 1 Nevar Merried 2 Married	12. Was Decedent Ever Armed Forcas? 1 Yas 2 No If Yas, Giva	in U,S. 13	Wes Dece If Yas, spe		dispanic Ori en, Maxica Specify:		cify Yas or N Rican, atc.)	Btac	e - Amaric k, Whita, Wh	
à	3 Widowed 4 Divorced	Yeer or Detes:		10140	200410	Specify.			Specify	. *****	166
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E	Etamentary/Secondary (0-12)	Collega (1-4or 5+)		emaker		,			Own Hom	e	
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Be	- respectively to the state of								i, maiouit ournam	ru/	
10	Charlie Stalnake							rritt			
	19a. Informant's Name/Ralationship								ber, City or Town,		Code)
	John A. Kopsitz /	Husband	4505	Maha	n Ro	pad, S	Silve	r Spri	ng, MD 2	0906	
	20a. Mathod of Disposition 1 ⊠ Burial 2 □ Cremetion 3 4 □ Donation 5 □ Othar (Spec	Ramovet from Stata	Ob. Placa of Disposematary, cr George V	amatory or o	ther pla		etery	1 Pate 2 2 2 2 2 2 2 0 0 0	20c. Location - Adelphi		own, Stata
	23a. Pent1. Entar tha diseasa, or conshock, or haart failura. List onl	y offa causa on aach lina.		500 U	nive	ersity	Blv	d W.	al Home, Silver		ng, MD 200 Approximate Intarval Batween Onset and Death
ner	disease or condition rasulting in death)	a. Cerebrova	ascular to (or as a cons					4		1	l week
il Examiner	Sequentially tist conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disease or injury	bDua	to (or as a cons	equance of):		40					
//Wedical	that initiated evants rasulting in death) Last	Dua i	to (or as a conse	equanca of):							
Physician/	Part II. Other eignificant conditions	contributing to death but no	t rasulting In tha	undarlying o	ausa gi	ven in Part	t.	23b. Dfd	I tobacco use cor	ntribute t	o the cause of dea
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Completed I									s an autopsy ormed?	av cc	fara autopsy finding vailable prior to emplation of cause death?
E								10	Yas 2 No	1	Yas 2 No
0	25. Was casa rafarred to medicat				-	26 Diag	a of Dooth	(Check only	onel	1	
0	axaminar? 1 ☐ Yas 2 ☐ No	Hospital:	a∏ 5D(0*		O					(0	4.0
-	27. Mannar of Death 1 Naturat 5 Pending	28a. Data of Injury (Month, Day Yes	2 ER/Outpati 28b. Time Injury	of :	28c. Inju Wo	ry at			how injury occur		ry)
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edical C											
Me	29b. Signeture end Atla of certifier	and mannar stated.	0	29	c. Licen:	sa number			29d. Data signe	d (Month,	Day, Year)
	Hure	udli	ret	Drin) D	38262	2		Octobe	r 30	, 2000
	20 Name and address of second	acompleted acuse of death	(Hom 22a) (Ti	Drint'					00000		, _000
	30. Name and addrass of person who										
	A. Mendhiratta,			vd., S	uit	e 340	, Roc	kville	, MD		
State	31. Dete filed (Month, Day, Year)	32. Registrer's S	signeture 4	1							
strar	001 91 7	JUU JUU	J.	10,00	KR2	/					

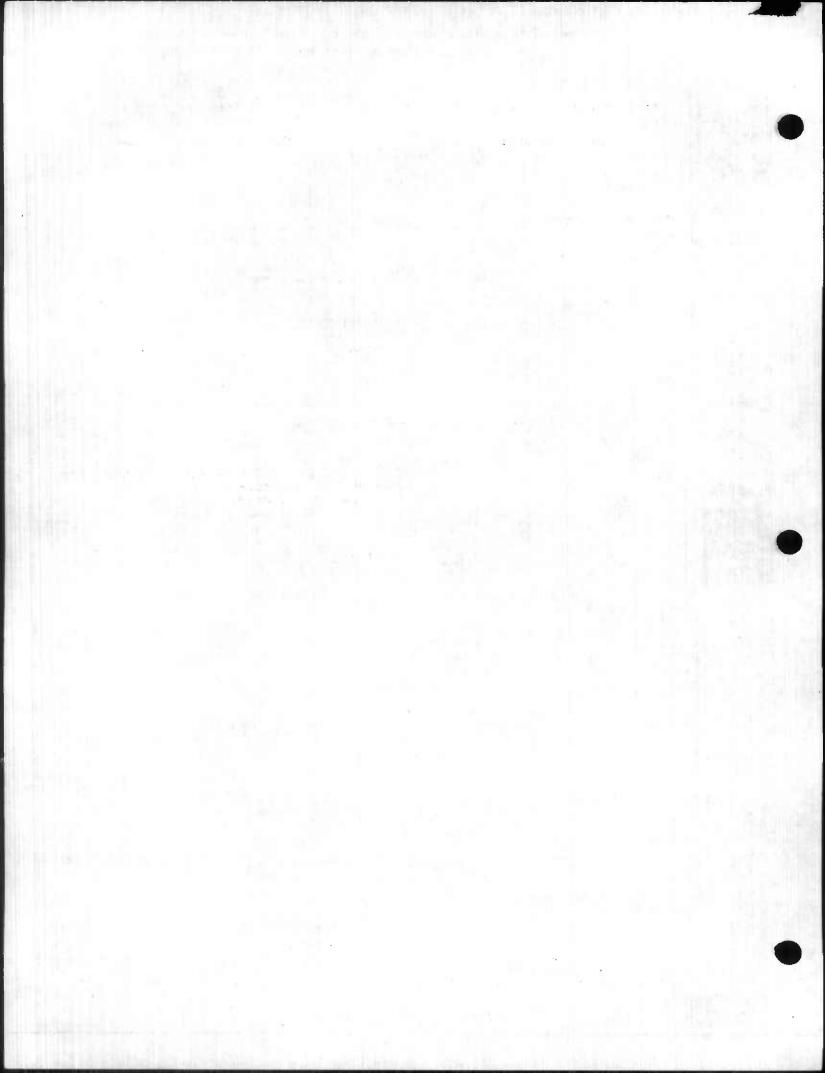


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	1. Decedent's Neme (First, Middle, Last)					2. Dete of Dea		Year	3. Time of Death
ysician	Anne Katherine	Staley	Kriemel	mever		October	Day 27, 20	127	8:24 PM
ical iner	4a Facility Nema (If not institution, give s				4b. City, Town, or	Location of Death			0.24 111
er	Howard County Ger		ital		Colum	hia	По	ward	
H	5. Social Security Number 6. Sex		(In yrs. last birtl	day) If Under 1 Yas					ace (State or Foreign
	214-16-5615	M 25€ F		rs. Months Dey		(Month, Day	, 1916	Count	nce (State or Foreign y) yland
	Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10	d. Inside City Limits
7		- 1							1 ☐ Yes 25 No
Funeral Director	Maryland Howard		Colu	7					
Š	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Countr	ry?
ē	5400 Vantage Point	Road, #1	01	210			USA		
	11. Merital Stetus	12. Was Decedent Ev Armed Forces?	var In U,S.	13. Was Decedent of If Yas, specify Co	f Hispanic Origin? (Specify Yes or No- rto Rican, etc.)	14. Raci	e - Americe k, White, e	
	1 Nevar Married 2 Married	1 Yas 2 No If Yes, Give		1 ☐ Yes 2 ☒ N					
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Die.	(Specify only highest grade Elementery/Secondary (0-12)	College (1-4or 5+		(Give kind of work dor life. DO NOT use reti	red)	iking			
E	12	4		Teacher			Educ	ation	
Be Compieted	17. Fathar's Neme (First, Middla, Last)				18. Mother's Ne	me (First, Middle,	Maiden Sumam	na)	Tarakin and
0	Ira McDuell Staley	,			Myrt 1	e Ruch			
10	19e. Informant's Neme/Reletionship (Ty)		10h	Meiling Address (Stre			ar City or Town	State 7in (Cortel
	Betsy Tervo / Daug								
		ncer		200 Mt. Pl		Dete Lau	20c. Location -		
	20a. Method of Disposition 1 ■ Buriel 2 □ Cremetion 3 □ R	lamovel from Stete	cemeter)	Disposition (Neme of cremetory or other p	olece)	Dete	20C. LOCATION -	City of Tow	mi, Stela
	4 ☐ Donetion 5 ☐ Other (Specify)		St. Ma	rk's Cemet	ery 11	/1/00	Petersv	ille,	Maryland
	21. Signature of Full tirel Service License	90		22. Name and Add	dress of Fecility H	ines-Rin	aldi Fur	neral	Home
	1				w Hampshi pring, Ma		e 20904		
	23a Part 1. Entir the disease or compli shock, or heart failure 15st only on	cations thet caused to	he deeth. Do n					1	Approximate
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sici	Pert II. Other eignificant conditions con	tributing to death but	not resulting in	the underlying ceusa	given in Pert I.	23b. Did 1	lobacco use co	ntribute to	the cause of death"
T Y	D					10	Yaa 2 No	3 Prob	ably 4© Unknow
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2000	3 Suicide 6 Could not be determined	28e. Plece of Injur building, etc.	y - At home, fer (Specify)	m, street, factory, offic	De .	28f. Location (S City or Tox	Street and Numb vn, Stete)	per or Rural	Routa Number,
Ü				death occurred at the					
100	(Check only 2 Medical Examir	ner: On the basis of e and mannar stete		/or investigation, in m	y opinion, deeth occ	curred at the time,	dete end plece,	and due to	the ceuse(s)
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Medical	one) 29b. Signature and title of certifier	11	1	29c. Lica	ansa number		29d. Data signe	d (Month, L	Jey, Year)
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edicai	29b. Signature and title of certifier	MI) ,	DS	50778		October		
edicai				DS	50778		October	30,	2000

(Month, Day, Year) NOV 03° 2000 Registrar

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State of Maryland / Department of Health and Mental Hygiene

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Physic /Med		Decedent's Name (First, Mic Grace		nees	si					2. Date of Dea	r 17, 2	000	3. Time of Death 2130
Exam		4a Facility Name (If not institu College Vie			e				own, or Lo		Fre	of Death deric	ek
Funera Directo		5. Social Security Number 577–01–1421	6. Sex 1 ☐ M 2 🔀 I		94 Y		Under 1 Ye		r 24 Hrs. Min.	8. Date of Birt (Month, Day June	, 1906	9. Birthi Cour Mar	place (State or Foreign ntry) yland
Maryland of show Sed at	tor	Usual Residence of Decedent 10a. State 10b. Cour Maryland Mont			10c. City, Town Kensin							1	10d. Inside City Limits XYes 2 □ No
h with the M da or 28e-4 at be notifi	i Director	10e. Street and Number 10405 M	uir Place				10f. Zip Cod	895			10g. Citizen of V U.S.A.		ntry?
020 uns after deatl ef., or flams 2 Examiner mu	by Funeral	11. Meritel Stetus 1 Never Married 2 M WWWidowed 4 Divorce	arried 1 Yes,	Forces?	Ever in U,S.	#Ye	S Decedent es, specify C	uban, Mexica	in, Puerto	ecity Yes or No- Rican, etc.)	Blac	e - Americk, White,	
Maryland 21215-0020 d 2 should be filed within 72 hours at the and Mental Hygiene. The marked other than "natural", or traumetic event, the Medical Exam	Completed		ent's Education hest grade complete College	ed) e (1-4or 5		(Give kind life, DO	t's Usual Oc d of work do NOT use re	ne during mo tired)	st of work	ing	16b. Kind of Br		Company
yland by the Mantal Hygerked other affic event,	To Be C	17. Father's Name (First, Midd John	Stephen	Bow	lus			3,555	Berth	e (First, Middla,		wlus	
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altimore, mit. Pages 1 a partment of Has portant: if Nem		20a. Method of Disposition 1 ☒ Burial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other		om Stete	20b. Place of cemetery Pleasar	r, cremati	ory or other	tery, O	t. 20	, 2000	Burkitt		le, Md.
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Certain Street S		shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants		esp spir	Due to (or as a co	onseque	nce of):	mor	sia				Interval Batween Onset and Death 12 hours 24 hours
death certific death certific	3	resulting in death) Last Part fl. Other eignificant cond	d					givan in Par	I.	23b. Dld (obacco usa po	ntribute t	to the cause of death?
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requiper v	Completed by Physician	Alzhein	er's D)ew	vente	2				24a. Was perfo	an autopsy med?	81	/era autopsy findings vailable prior to ompletion of cause I death?
Vital Relationary Includes Contilicate has rector, page 2	Be Cor	25. Was case referred to medi	cal					26. Pla	ca of Deat	1 □ '	•	1	Yes 2 No
on of ling Phys After this funeral di	10	1 Yes 2 No 27. Manper of Death 1 Natural 5 Pen	28a. Da	☐ Inpatie ate of Injur fonth, Day	y 28b. Ti	-	28c. I	Other: 4 12/1 njury at Work? 1 Yes 2		ome 5 Resident	dance 6 Ott		(y)
5 g # 5 E	edical Certification:	3 Suicide 6 Cou 4 Homicide dete	mined 288. Pl	ace of Injuried	iry - At homa, far :. (Specify)	m, street	, factory, off	ce		28f. Location (3 City or Tox		oer or Rur	ral Route Number,
he Hospital in 24 hours he Funeral pletely filled	edicai		ying Physician: To al Examiner: On th and m		examination and								
To the within 2 To the comple	2	29b. Signature and title of cert	7 0		,		29c. Lic	ense number			29d. Date signe		
		30. Name and address of pers	on who completed o	ause of de	eeth (Item 23a) (Type, Pri	nt)	3210	ì	oriok	Octobe Maryland		
S	tate	Lloyd E		2. Registra	r's Signeture	4/0 1	&	1		errck,	naryrall	1 411	02
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DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene [] 36200 Certificate of Death 2. Data of Death 1. Decedent's Name (First, Middla, Last) 3. Time of Death Month October 11, 2000 **Physician** John Kish, Jr. 1:58 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Citizens Nursing Home Frederick Frederick 7. Aga (In yrs. last birthday) 86 Yrs. If Under 1 Yaar | If Undar 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Funeral Days 15M 20 F 177-09-3189 Pennsylvania Director Usual Rasidence of Decedant 10e. State 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or harns 23s or 25s-1 show iens.
- than "natural", or items 23s or 25s-f shor the Medical Examiner must be notified at Maryland Frederick Frederick 1 XYas 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? Funeral 1900 Rosemont Avenue 21702 14. Race - Amarican Indian, Biack, Whita, atc. 12. Was Decedent Ever in U,S.
Armed Forcas?
1 ☐ Yes 2 ☑ No
If Yas, Giva
Yaar or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 ☐XNo Specify: Specify: White þ 3 DWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) Transformer Mfr. Laborer 17. Father's Nama (First, Middla, Last) 18. Mothar's Name (First, Middle, Maidan Sumama) 2 should be 1 and Mental 1 John Kish Julia Borbos 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) important of Health as Important: if them 27 is a any injury or other to 2006. Thomas Kish/Son 1105 Merridale Blvd., Mt. Airy, Maryland 21771 Baltimore, 20b. Piace of Disposition (Nema of cematary, crametory or other place)
St. Rose Cemetery Data 20c. Location - City or Town, Stata 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Oct. 14, 2000 Hermitage, Penna. 4 Donation 5 □ Othar (Specify) 21. Signatura of Funeral Sarvice Licensee 22. Name and Addrass of Facility Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec of shock, or heart failure. List only one ceuse on each line. Approximate Interval Batween Onset and Daath **Physician** Immediata Cause (Final disease or condition rasulting in death) /Medical remers wars Examiner Dua to (or as a consequance of) Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Dua to (or as a consequence of): and ate has been signed by the attending physician page 2 should be detached for use as the buna Box 68760. Dua to (or as a consequence of): P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy tindings available prior to complation of cause of death? Completed 24a. Was an autopsy performed' this certificate has 1 Yas 2 2 No 1 Yas 2 No al or Attending Physician: The safer death.

In Director: After this certificate of in by the funeral director, pa Be 25. Was casa refarred to medical 26. Place of Daath (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No 0 4 Nursing Homa 5 ☐ Rasidance 8 ☐ Othar (Specify) 27. Manufer of Death 1 Minatural 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Medical Certification: 5 Panding invastigation 1 Yas 2 No 2 Accident To the Hospital or Attar within 24 hours after de-To the Funeral Directo completely filled in by th 3 Suicida 6 Could not be 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data and piece, and due to the cause(s) and manner stated. and tive of certifier 29d. Data signad (Month, Day, Year) 29b. Signatur 29c. Licansa number October 11, 2000 of person who completed causa of death (Item 23a) (Type, Print)

State Registrar 31. Data filed (Month, Day, Year)

OCT

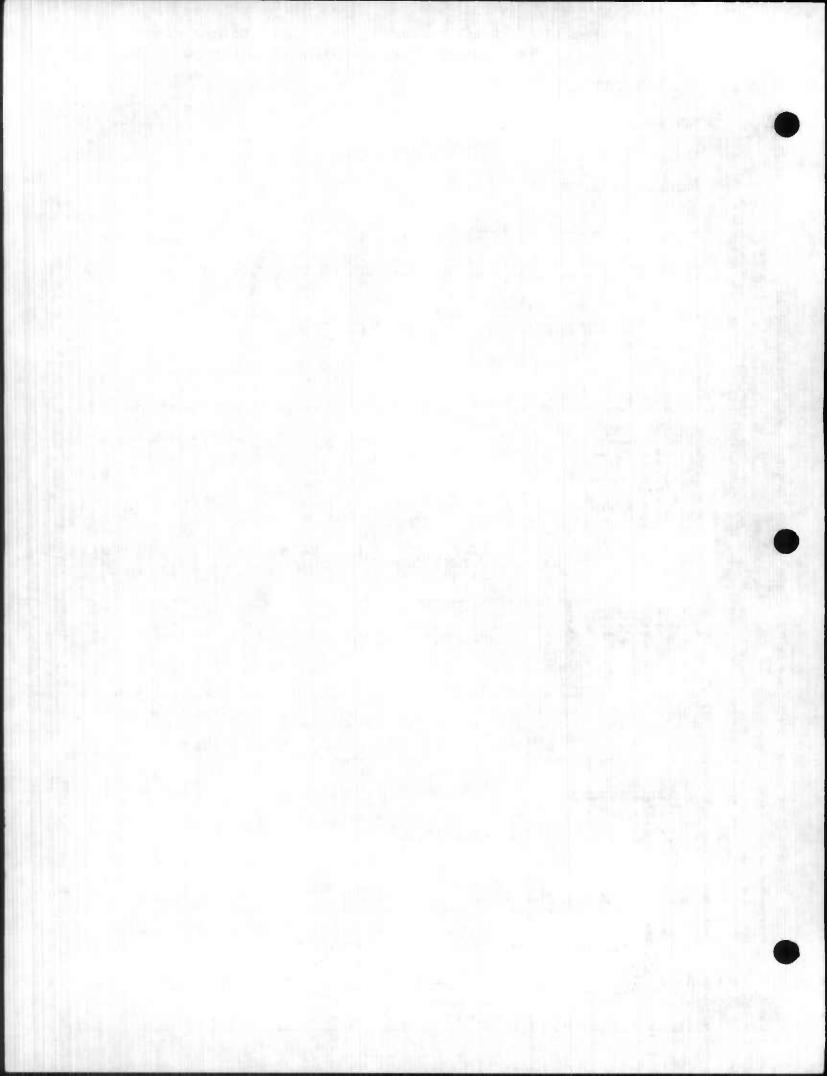
DHMH 16 Ray 6/95

32. Registrar's Signatura

2000

8

Bayers.



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

EDITH KLIPP

Physic /Med Exam

Funera Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic avant, the Medical Emmine must be notified anone.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

To the Hospital or Attanding Physician: The law requires that the death certificate be execute within 24 hours started death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-train

Division of Vital Records, P.O. Box 68760,

1. Decedent's Nam												
Edith		Last) Iorningst	or Klin	T				2. Date of De Month OCTOBE	Day	, 2000	Year	3. Time of Death 4:20P.M.
4a Facility Name (Ρ		4h City To	wn orte	ocation of Deat	- T	County		11201111
RT.15 AT							DERIC			REDE		
5. Social Security I	Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Yes		24 Hrs. Min.	8. Date of Bir (Month, Da 11-24-	irth		9. Birthpi	ace (State or Fore
220-03-		1□ M 2□ F	80	Yrs.	Months Day	S Hours	IVIII.	11-24-	1919		Fred	erick, M
Usual Residence of	of Decedent 10b, County	20,000	10c. Cit	y, Town or Lo	cation						10	d. Inside City Lim
MD	Frede	rick		rederi								1 Yes 201
10e. Street and Nu	umber				10f. Zip Code				10g. Citi	zen of W	hat Count	ry?
7118 Mou	untainda	le Court			2170	2			Unit	ed S	tate	S
11. Marital Status 1 Never Man 3 XWidowed	rled 2 Marrie	12. Was Dec Armed F 1 Yes If Yes, G Year or	cedent Ever in U orces? 2X No ive Dates:	H	Vas Decedent of Yes, specify Co	uban, Mexican	n, Puerto	ecify Yes or No Rican, etc.)		Black	- America c, White, e White	itc.
(Spe	15. Decedent's	a Education grede completed)	16a. Deced	ent's Usual Occ kind of work dor OO NOT use ret	upation ne duning mos	t of work	ing	16b. Ki	nd of Bus	siness/Ind	ustry
Elementery/Sec		1	(1-4or 5+)			ired)		8	07.	n ho		
17. Father's Name	(First, Middle, L	ast)		ПОШ	emaker	18. Mothe	er's Name	e (First, Middle				
John Mon												ingstar
19a. Informant's N				19b. Mailin	g Address (Stre							
		de/ daug	hter		East S							
20a. Method of Dis		de/ daug	20b. F	Place of Dispos	sition (Name of		TITU	Date .			City or To	wn, State
		3 Removal from	State		natory or other p		rdon	c 11_2_	2000	F	rodo	rick, MD
21. Signature of F	5 Other (Spi		110		. Name and Add							,
21. Signature of 1	a a a a a a a a a a a a a a a a a a a	1	2									, r.A.
C) py	mony	Tele	erson	10	4 East	Main S	tree	t, Thu	rmont	, MD	21	788 Approximete
23a. Part 1. Phter shock, or her	art feilure. List o	nly one ceuse on	eech line.	00 1101 0111		,g,						Interval Between Onset and Deeth
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resulting in death)	onditions, mmediate erlying r injury is Last	b	Due to (c	or as a consequence as	uence of): uence of):	given in Part I	t.	1 = 24a. Wa		□ No	3 Prot	re autopsy finding
resulting in death)	onditions, mmediate erlying r injury is Last	b	Due to (c	or as a consequence as	uence of): uence of):	given in Part I	l.	1 = 24a. Wa	Yes 2 s an autopformed?	□ No	24b. We ave	ore autopsy finding illable prior to inpletion of cause death?
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State

Registrar

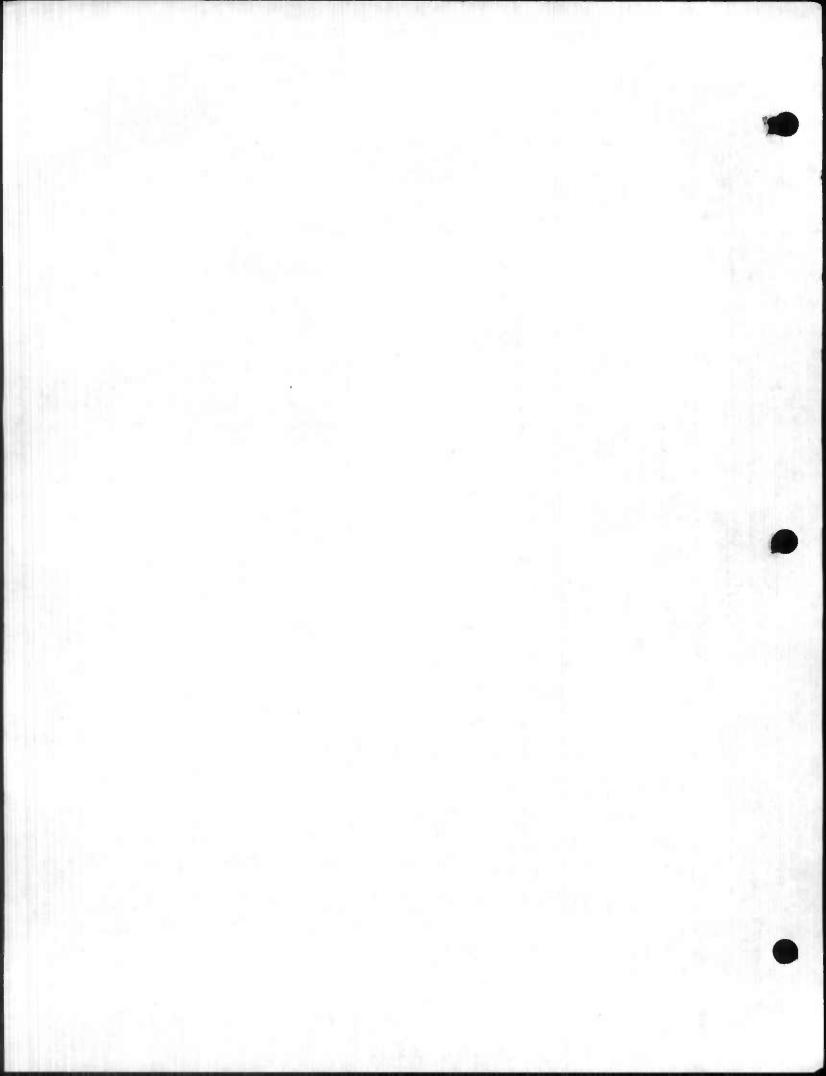
MARIANIOS

31. Date filed (Month, Day, Year)

32. Registrar's Signature

NOV 0 1 2000 >

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Dete of Deeth 3 Time of Death 1. Decedent's Name (First, Middle, Last) Karagiorgis October 4blatty, Town, or Location of Death **Physician** 5:55 AM Outober 29, 2000 Demetrious /Medical 4c. County of Death 4e Fecility Name (If not institution, give street and number) Examiner Baltimore Rehabilatation and Extended Care Baltimore 8. Dete of Birth (Month, Dey, Year)

Jan. 28, 1931 Greece If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Months Deys Hours Min 69 Yrs 055-30-5559 Director Usuel Residence of Decedent 10a. Stefe 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28e-f sho the Medical Examiner must be notified at 1□ Yes 2□No Virginia Loudoun Directo Potomac Falls 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20544 Morningside Terrace 20165 U.S. 06 A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Meritel Stefus 1 Ves 2 No If Yes, Give Yeer or Detes: 1 Never Merried 20 Merried Baltimore, Maryland 21215-0020 Specify: Caucasian 1 ☐ Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) of filed withing the file other than Owner - Operator Restaurant 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be should be is marked 2 Evangelos Keragiorgis Vasiliok Serpanou 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 at Department of Health and Important: If ham 27 is n any Injury or other treun 20544 Marningside Terrace Patomac Falls, Va. 20165. Dete 20c. Location - City or Town, State Mercina Karagiorgis (wife) 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition # Donetion 2 Cremetion 3 Removel from Stete Arlington National Cemetery11-3-00 Arlington, Virginia 21. Signature of uneral Service Licensee 22. Name end Address of Fecility Loudoun Funeral Chapel P.O. Box 1316 ill or complications that caused the death. Do not enter the mode of dying, such as carefactor respiratory arrest, lat only one cause on each line.

| Approximate | Approxima 23e. Part1. Enter the shock, or heert fall **Physician** /Medical Immediate Cause (Final Alzheimer's type Dementia. Zyears disease or condition resulting in deeth) Examiner Due to (or es e consequence ot) Examine sician and burial-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): physician s the burial Box 68760 Physician/Medical Due to (or es a consequence of) 980 Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à Parkinson Disease det signed b Division of Vital Records. PV 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24a. Wes an autopsy performed? Completed 1 ☐ Yes 2 PINO 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4D Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? Certification: 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred After 1 Neturel 5 Pending death. 1 ☐ Yes 2 ☐ No investigetion 2 Accident Director: 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) or A 4 THomicide To the Hospital within 24 hours a To the Funeral C completely filled 1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29a, Certifier Medical (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) Uctober 29,2000 North Greene Street 30. Name and address person who completed cause of deeth (Item 23a) (Type, Print) 10 Colvin Balti more Maryland

DHMH 16 Rev 6/95

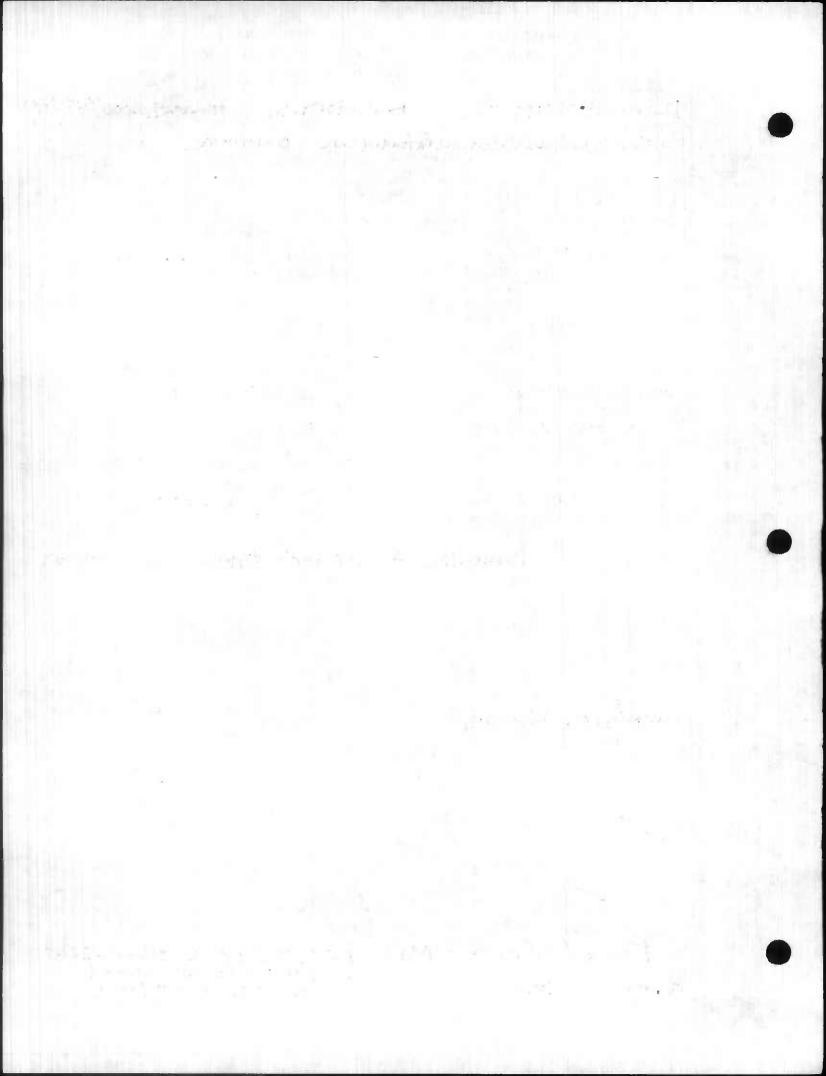
State

Registrar

31. Dete filed (Month, Day, Year)

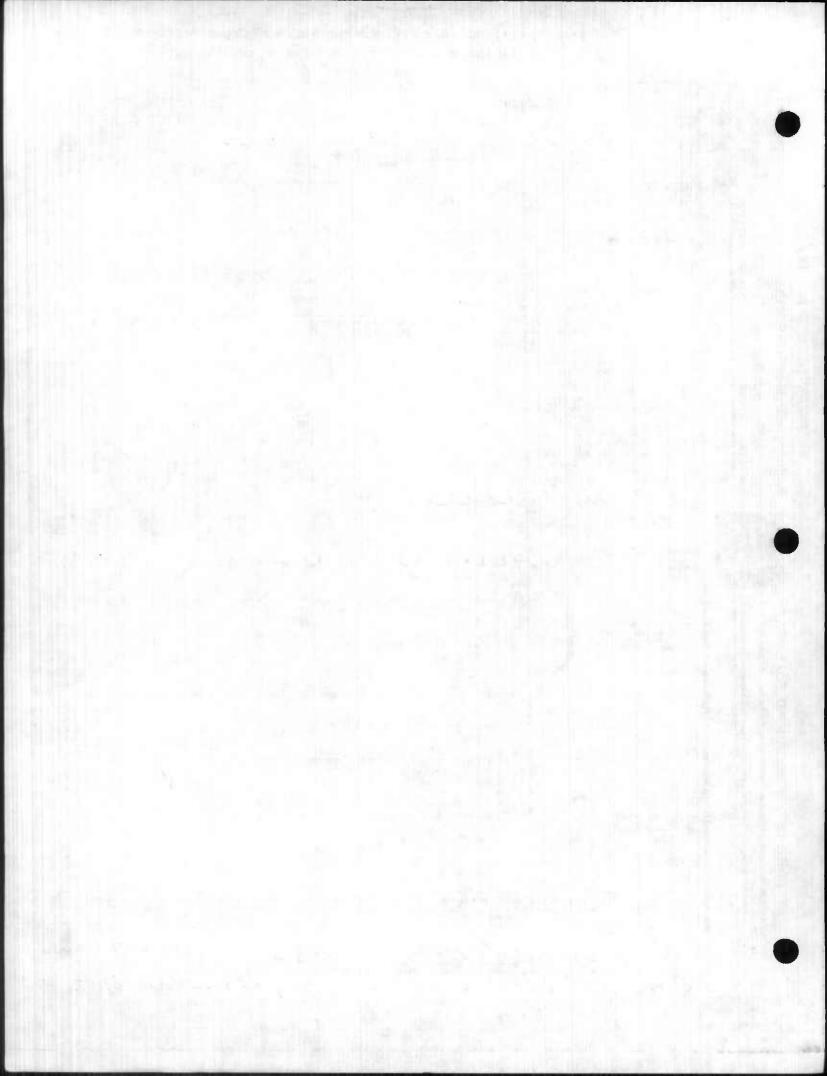
32. Registrers Signeture

3 1 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36203

			Certifica	te of Death	Re	g. No.	
Physician	Decedent's Nama (First, Middla, Las.	EORGE	LITTLE		2. Data of Death		3. Time of Death 2000 9:30 an
/Medical Examiner	4a Facility Nama (II not institution, giva Heartland Healt				Location of Death	4c. County of	
Funeral Director	5. Social Security Number 6. Se			or 1 Yaar Hundar 24 Hrs Days Hours Min		Year 916	9. Birthplace (State or Foraig
Maryland 4 show lad at	Usual Rasidenca of Decedant 10a. State 10b. County D. C	10c.	City, Town or Location Washi	ngton			10d. Inside City Limits 1 Yas 2 □ No
ther death with the Ma r thems 23s or 28s-1 s siner must be notified Funeral Director	10e. Street and Number 1001 16th St.	, N.E. #1	0 1	ip Coda 2000.		g. Cilizan of W Unite	hat Country?
by	11. Merital Status 1 Nevar Married 2 Married 3 Midowed 4 Divorced	12. Was Decedant Evar in Armed Forcas? 1 SYas 2 No If Yas, Giva 145 Yaar or Datas: 15	13. Was Dec If Yas, sp	edani of Hispanlc Origin? (ecify Cuban, Maxican, Pua 2 No Specify:	Specify Yas or No- rto Rican, atc.)		- Amarican Indian, c, Whita, atc. Black
ed within 72 hours at typiene. wer then "setural", or it, the Medical Exam Completed by I	15. Decedant's Edi (Specify only highast grad Elementery/Secondary (0-12) 12th	cation le completed) Collega (1-4or 5+)	16a. Decedent's Us (Giva kind of v lifa. DO NOT	ork dona during most of we	orking		sinass/Industry
d 2 should be filed th and Mental Hyg 7 is marked other traumatic event, To Be C	17. Falhar's Nama (First, Middle, Last) Wa]	ter Little		18. Mother's Na	ma (First, Middla, M Annie	Baile	
2 shot t and h is man	19a. informant's Name/Ralationship (T			ss (Straat and Number or F			
mil. Papes 1 and partment of Health portant: If them 27 y Injury or other 1	Lessie Hunter 20a. Mathod of Disposition 1 Surial 2 Cremation 3 St 4 Donation 5 Other (Specify	200 Ramoval from Stata	o. Place of Disposition (N cametery, crematory of	ckridge Dr ama of other place) ln Cemeter	Data 2		KS 66047 City or Town, Stata entwood, Md.
Departm Departm Importa any Inju	21. Signatura of Funaral Sarvice Licens		0	and Addrass of Facility Maryland	Capito		ash., D.C.
Physician /Medical Examiner	23a. Part1. Enter the disease or comp shock, or heart feilura. List only of Immediata Causa (Finel disease or condition rasulting in death)	ALZH		s Dise		51,	Approximate Interval Batween Onsat and Death Years
the attending physician and the attending physician and had for use as the burial-transit ysician/Medical Examiner	Sequentially list conditions, if any, leading to Immadiate causa. Enter Undarthying Cause (Disease or injury that initiated avants rasulting in death) Last	c	o (or as a consequanca o				
4 70	Part ii. Other significant conditions co	ntributing to death but not	rasulting in tha undarlying	causa given In Pert I.	23b. Dld tot		stributs to the cause of death
sicien: The law requires that it certificate has been signed by director, page 2 should be detend to Be Completed by Pl					24e. Wes en perform	ned?	24b. Were autopsy tindings evailable prior to completion of causa of death? 1 Yas 2 No
ystelen: The law requires the secretificate has been signed director, page 2 should be of the Board of the Bo	25. Was casa refarred to medical examiner?	Macaital		Other	eath (Check only one		
hya his	1 ☐ Yas 2 ☐ No 27. Menner of Death	Hospitel: 1 ☐ Inpatient 2 28a. Data of Injury (Month, Dey Year	2 □ ER/Outpatient 3 □ 1	OOA Other: Wursing 28c. Injury at Work?	Home 5 ☐ Rasidar 28d. Dascribe hor		
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To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of Injury - A building, atc. (Spe	t homa, farm, street, factority)	ory, office	28f. Location (Str. City or Town,		er or Rural Route Number,
To the Hospital of within 24 hours at Vo the Funeral D completely filled in Medical Ce				d at the time, date and placen, in my opinion, deeth occ			
Y within com	29b. Signature and titla of certifier	n al re		DOISS		_	(Month, Day, Year)
State	30. Nama and addrass of person who con the control of the control	ompleted causa of death (I	tam 23a) (Type, Print)) 4203 Q gnatura	veensbury	Rd My a	Hill	1272000 10 2078/



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death 2 Date of Death Day Month **Physician** 29, YONG-WOO LIDE OCT. 2000 10:00 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MUNCASTER MILL RD. ROCKVILLE
If Under 24 Hrs. 8, Da 4230 MONTGOMERY If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 10 M 2 F Months Days Hours Min Yrs. 8 Director KOREA NONE Usual Residence of Decedent r 28a-f show Lnotified at 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryla 1 No 2 No Director MD. MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 8 edical Examiner must be "natural", or items 23a 4230 MUNCASTER MILL RD. 20853 KOREAN Funeral 14. Race - American Indian, Black, Whita, etc. 12. Was Dacedent Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Maritat Status hours after 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yas 2 No Specify. Specify: À 3 Widowed 4 Divorced ASTAN Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry a filed within 7. al Hygiens. I other than "n the Me Elementary/Secondary (0-12) College (1-4or 5+) STUDENT SCHOOL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be nd Mental is marked LIBIS KYUNG-RYUL 2 JEONG-LAN LEE gest 1 and 2 also graffment of Health and Is important: If Isan 27 is many liquity or other 19a. Informant's Name/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) LEE/MOTHER JEONG-LAN #10 SAME AS MEULT Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) 10/30/00 CHAMBERS CREMATORY RIVERDALE. MD. 21. Signature of Funaral Service Licenses 22. Name and Address of Facility pomerical MOOO91 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737 23a. Part 1. Enter the disaasa, or complications that ceused the death. Do not anter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Finat disease or condition resulting in death) HEPATIC AND PULMONARY FAILURE Examiner Due to (or as a consequence of) Examiner WIDESPREAD METASTASES attending physician and for use as the burial-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury Dua to (or as a consequence of): certificate be execu 68760 RENAL CELL CARCINOMA Physician/Medical that Initiated events resulting in death) Last Dua to (or as a consequenca of): Box (P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? the detached 1 Yes 20 No 3 Probably 4 Unknown signed by Division of Vital Records. py should be 24b. Were autopsy findings be 24a. Was an autopay performed? available prior to completion of causa of death? Complet page 2 has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate 25. Was cese referred to medicel examiner? 8 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 💆 Residence 6 ☐ Other (Specify) To 1 Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred Hospital or Attending Pi
 24 hours after death.
 Funeral Director: After t 28b. Time of Certification: 5 Panding investigation 1 Naturat Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. Licanse number D20487 OCT. 30, 2000 30. Name and address of person who completed ceusa of death (ttem 23a) (Type, Print) GREGORY H. REAMAN M.D. 111 MICHIGAN AVE. N.E., WASH, D.C. 31. Data filed (Month, Day, Year) OCT 31

DHMH 16 Rev 6/95

State Registrar

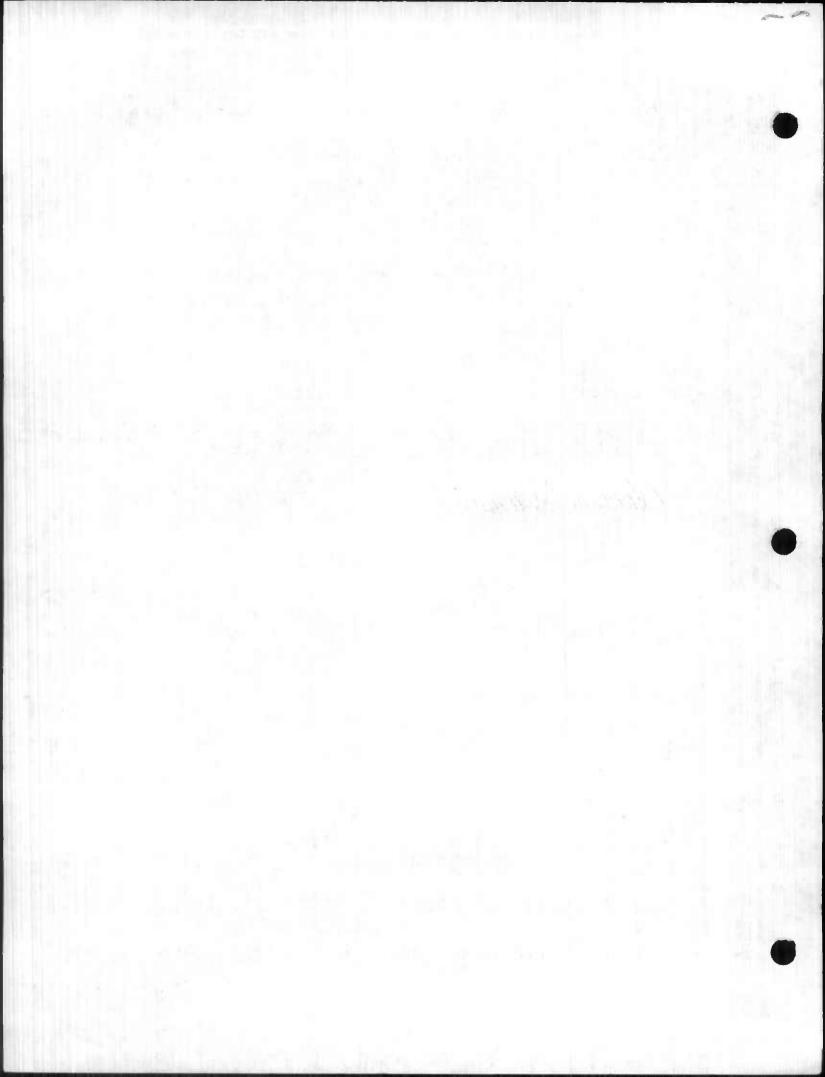
32, Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Data of Death 1. Decedent's Nama (First, Middla, Last) 3. Time of Death **Physician** Laver Norma)ctober 26,2000 20:00 /Medical 4e Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALLIMORE City Hospital Johns HOPKINS N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) **Funeral** 1□ M 2⊠ F Days 65 Yrs. Director 399-32-1456 Wisconsin Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ₩XX 2 No 28a-f Directo Florida Lee Fort Myers Beach 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Code must be n 22748 Island Pines Way 33931 USA 12. Was Decedant Ever in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Ricen, atc.) 14. Race - Amarican Indian. 11 Meritel Status Black, White, etc. 1 ☐ Yes 220 No If Yas, Giva Yaer or Datas: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 8 1 Yes 20No Specify: Specify: be filed within 72 hours at tal Hygiene. d other than "natural", or event, the Medical Exant þ 3 ☐ Widowed 4 ☑Divorced White 16e. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Realtor 4 Real Estate 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Name (First, Middla, Maidan Sumama) Pages 1 and 2 should be fit timest of Health and Mantal H tant: If Nem 27 is marked oil fury or other traumatic ever Benjamin Spieth To Francelia Rhiner 19a. Informant's Name/Relationship (Type, Print) Donna and Susan Lauer/Daughters 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 31 Field Stone Drive, Apt., #C4, Hartsdale, NY 10530 Oct.28, 20b. Place of Disposition (Nama of 20a. Mathod of Disposition 20c. Location - City or Town, Stata Northern reverse phaneles 1 ☐ Burial 2 ØCramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Funeral Services 2000 Chantilly, Virginia 21. Signature of Funeral Sarvice Lips 22. Name and Address of Facility
Northern Virginia Funeral Services 14522L Lee Road, Chantilly, Virginia 20151 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximata Intarval Betwe **Physician** Immediata Ceusa (Finel disaasa or condition resulting in death) Multiorgan System 2 weeks **Examiner** Dua to (or as a consequence of) Physician/Medical Examiner Massive Polmonary 3 weeks Embous The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Undarlying Cause (Disease or injury that initiated events Dua to (or as a consequence of): Box 68760, Chronic obstructive Pulmonary Disease Zyears that initiated events rasulting in death) Last Dua to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Obstructive Pulmonary Disease requiring of Vital Records. by 24b. Wara autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed Right Long transplant complicated by massive Pulmonary Embolus, and Multiorgan System 1 Yas 20 No 1 ☐ Yas 2 ☑ No Failure or Attending Physician: 25. Was casa referred to medical 26. Placa of Death (Check only ona) Hospital: 1 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yes 25 No Certification: To 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Describe how Injury occurred Division 5 Pending invastigation 1 W Natural death. 1 Yas 2 No 2 Accident 24 hours after deat Funeral Director: 6 Could not be detarmined 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 3 Suicida 28a. Place of Injury - At homa, farm, straat, fectory, office building, atc. (Specify) 4 - Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 ş 29d. Data signed (Month, Day, Year) 29b. Signature and titla of certifian 29c. License number 2 Chrisph D. Willaws, M.D. RES-000 2 October 26, 2000 30. Name and address of person who completed ceusa of death (Item 23a) (Type, Print) Williams, M.D. 600 North Wolfe Street, Baltimore Maryland 21287-9106 31. Dete filed (Month, Day, Year) 32. Registrar's Signatura State 30 2000 Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedent's Nama (First, Middle, Last) 3. Tima of Death **Physician** 2000 OCTOBER LOTTIE MAUDE MAINHART LEWIS 8:25am /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) **Examiner** FREDERICK COLLEGE VIEW CENTER FREDERICK H Under 1 Yaar | H Under 24 Hrs. 8. Data of Birth Months Days Hours Min. JUNE 1902 Birthplace (Steta or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthdey) **Funeral** 1 M 2 F 98 Yrs. 216-40-5832 MD Director Usual Rasidence of Decedant the Maryland 10e. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahov the Medical Examiner must be notified at MD MONTGOMERY DICKERSON 1 ☐ Yas 2 No Director 10f. Zip Coda 10g. Citizen of What Country? 10e. Street and Number "natural", or Nema 23a or 20842 18900 PEACHTREE ROAD U.S.A. Funeral filed within 72 hours after death 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 M No If Yas, Giva Yaar or Datas: 14. Raca - Amarican Indian, Black, White, atc. 13. Was Decedent of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 Nevar Married 2 Married Baitimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 18a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Businass/Industry than Elamantary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE DOMESTIC Hygiene 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Sumeme) Department of Health and Mental Important: If them 27 is marked of eny injury or other traumatic ever once. Pages 1 and 2 should be nent of Health and Mental LOTTIE M. HORINE LEWIS D. MAINHART, SR. 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 18725 DARNESTOWN RD., DICKERSON, MD 20842 GUY V. LEWIS, JR/son 20b. Placa of Disposition (Neme of cemetery, cremetory or other piece) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burlal 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify) FREDERICK, OLIVET CEMETERY 10/30 22. Nama and Addrass of Facility HILTON FUNERAL HOME BOX 86, BARNESVILLE, MD

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one ceuse on each line. 20838 Approximata Interval Between Onsat and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical nesmain 1 Wh Examiner Dua to (or as a consequence of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, taeding to immadiata causa. Entar Undarlying Cause (Diseasa or Injury that initiated avants rasulting in daath) Last signed by the attending physician and be detached for use as the burial-tran Due to (or es a consequence of): Box 68760, Physician/Medical Dua to (or as a consequence of) Division of Vitai Records, P.O. Part It. Other eignificant conditions contributing to daeth but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco uss contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy tindings available prior to complation of causa of death? 24a. Wes an autopsy performed? page 2 should Completed Peripheral Vadenta Didial 1 Yas 1 ☐ Yas 2 ☐ No this certificate Physician: Be 25. Was casa rafarred to medical 26. Placa of Daath (Check only one) Hospitat: 1 ☐ Inpatiant 2 ☐ ER/Outpatient Other: Nursing Homa 1 Yas 2 No 2 3 DOA 5 ☐ Rasidence 6 ☐ Othar (Specify) 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred edical Certification: 28c. Injury at Work? After or Attending 5 Pending invastigation 1. Natural 1 Yas 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 Suicide 6 Could not be 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida the Hospita Certifying Physician: To tha best of my knowledga, daeth occurred et the time, date and place, and due to the causa(s) end mannar as stated.

| Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and mannar stated. 29a Cartifier 29c. Licansa number 29d. Data signed (Month, Dey, Year) 29b. Signature and title of certifier 10/30 eurc-30. Name and addrass of person who complated causa of daath (frem 23a) (Type, Print) St. FREDERICK, M. JR 31. Data filed (Month, Day, Year)

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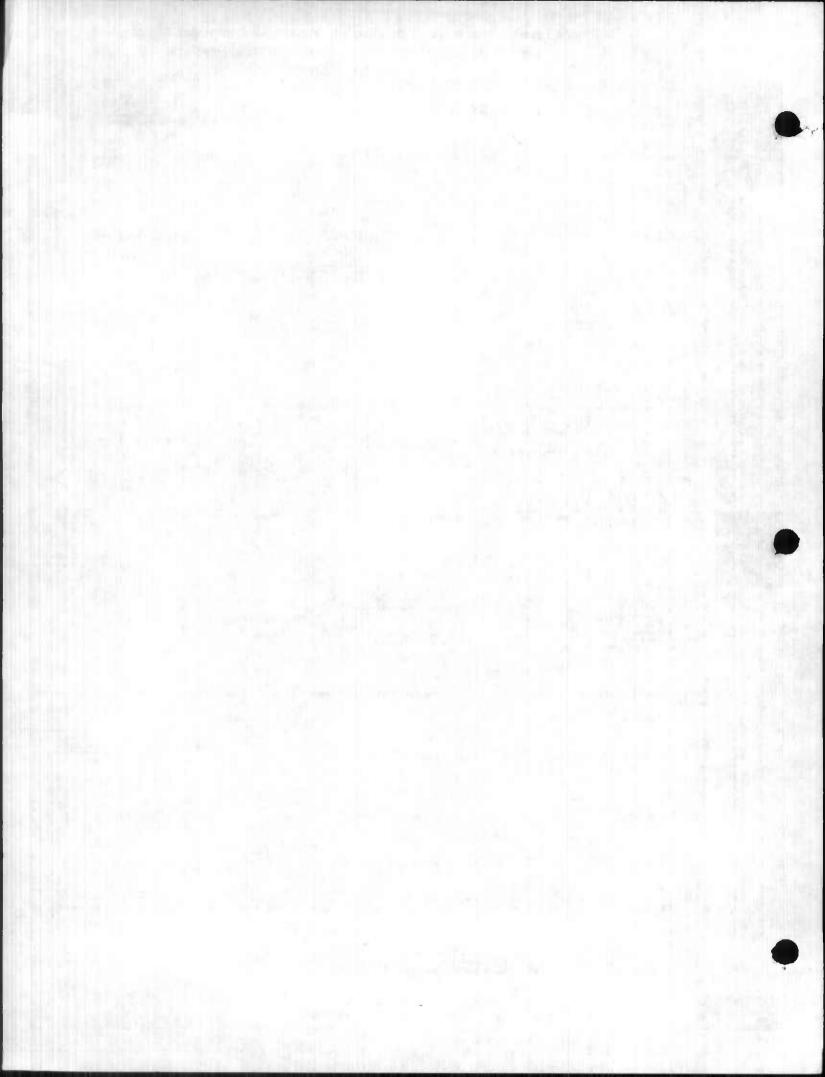
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Registrar

32. Registrar'y Signatura

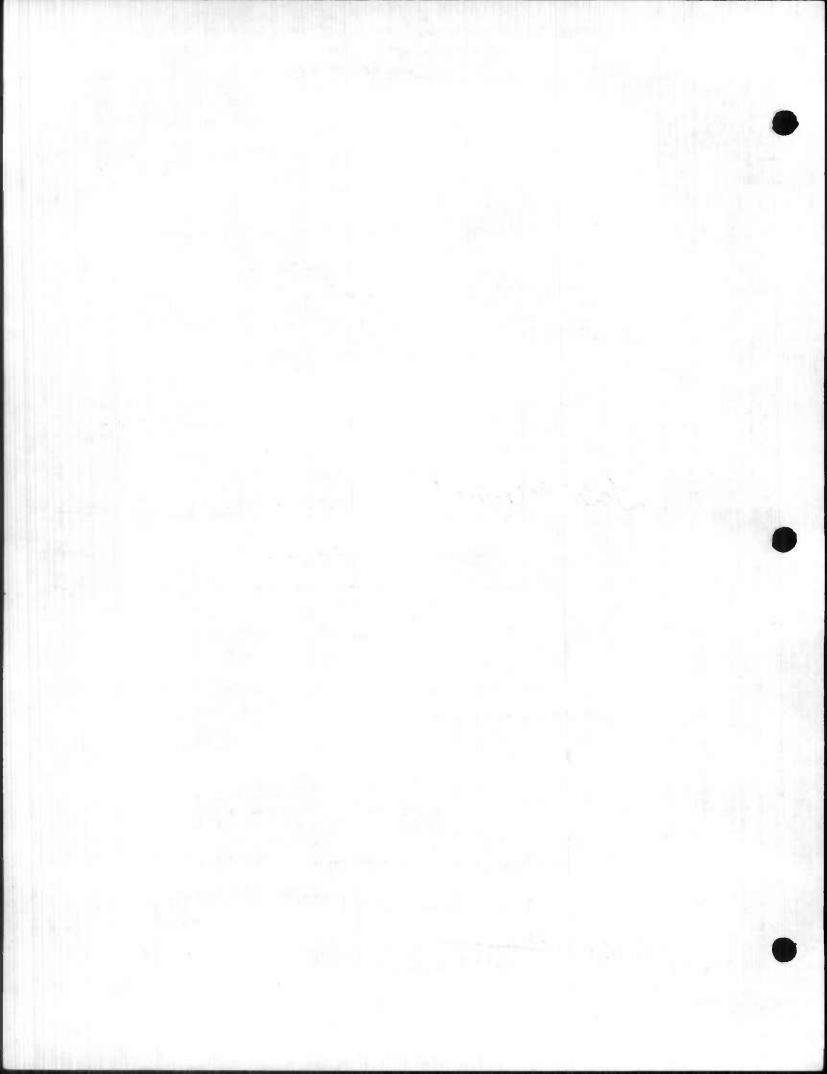
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State of Maryland / Department of Health and Mental Hygiene

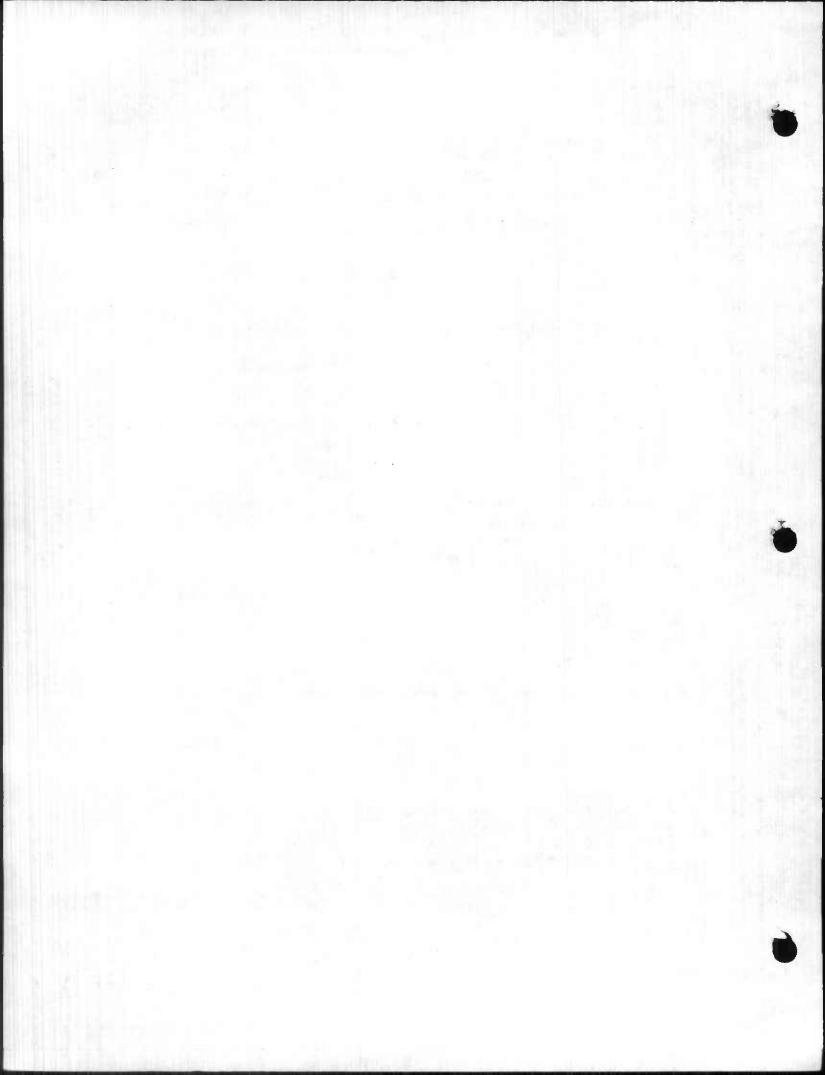
				Certific	ate of	Death		Reg. No.) 0	0201
	1. Decedent's Name (First, Middle,	Last)					2. Date of D		Year	3. Tima of Death
/sician ledical		R	obert I	E. Lowma	n		Octob			2:15pm
edicai miner	4a Facility Name (If not institution,	give street and number,)			4b. City, Town,	or Location of Dea			
	Frederick Memor	ial Hospti	al			Fre	derick	F	reder	ick
		5. Sex 7. A	ge (in yrs. last	birthday) If Ur	nder 1 Year		Hrs. 8. Date of B	irth	9. Birthple	ace (State or Foreig
Л	220-28-3799 Usual Residence of Decedent	127M 2□ F	66	Yrs.	ins Days	Hours	Nov. 1	9, 1933		yland
	10a. State 10b. County		10c. City, To	own or Location					10	Od. fnside City Limits
Directo	Maryland Frede	rick	Mt. A	-						
- I	10e. Street and Number			101.	Zip Code			10g. Citizen of 1		
Funeral	1304 South Main					1771		Unite		
by Fune	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	No	1 □ Ye		Hispanic Origin' pan, Mexican, P Specity:	? (Specify Yes or Nuerto Rican, etc.)	lo- 14. Rad Blac	ck, White, e	
	THE PERSON NAMED IN COLUMN	Year or Dates:			Invest Once			10h Kind of B		
name de la composición dela composición de la composición de la composición dela composición dela composición dela composición de la composición dela composición de la composición dela composición del composición del composición del composición dela com	15. Decedent's (Specify only highest	grade completed)	1	6a. Decedent's U	work done	pation during most of id)	working	16b. Kind of B	usiness/ind	ustry
	Elementery/Secondary (0-12) 1 2	College (1-4or	5+)			/ Opera		County	Cove	rnment
	17. Father's Name (First, Middle, La	et)		rire ri	gircei	-	Name (First, Middl			Timeire
000								o, morour coman		
1	Arthur Lowman	T 0:0		0. 14 7. 4 1.	100	Mae I		O T	Otata 7/2	0-4-1
	19e. Informent's Neme/Relationship						r Rural Route Num			
1	Catherine J. Lov	vman/ Wite		1304 Sou		in Stre	eet, Mt.A	20c. Location		
1	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from State	ceme	etery, cremetory	or other pla					
	4 ☐ Donation 5 ☐ Other (Spe		Pine	Grove	Cemet	ery 11	/2/2000	Mt. Air	cy, Ma	aryland
	21. Signature of Funesal Service Lic	censee	1			ess of Facility	h P. A.	Funeral	Home	
	1 Inles	Allen	W				Damascu			20872
	23a. Part1. Enter the disease, or co shock, or heart failure. List or	emplications that cause	d the deeth. D							Approximete Intervel Between
	SHOCK, OF Heart Tandre. List Of	ny one cause on each i							1	Onset and Death
1	Immediate Cause (Final	R	ani	ata.	2	il	dent		1	- 3 days
1	disease or condition resulting in death)	8.	Duatalana	aro in	70	~~~			1	20095
ı		Cere	forces	A consequence	en.	2-	Den 5		1	Alona
		b		a consequence		0-0-	1		- 1	as you.
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		Due to (or as	a consoquence	Oi).					
l	Cause (Disease or injury that initiated events	c	Due to force		-0.					
	resulting in death) Last		Due to (or as	a consequence	or).					
1		d								
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	Part II. Other significant conditions	contributing to death b	out not resulting	g in the underlyi	ng cause gi	ven in Part I.				the cause of death
١	lur	2 Conc	en				10	Yee 2 No	3 Prob	eably 4 Unknow
	0	1					240 Ws	s en autopsy	24b. We	era autopsy findings
				1000			per	formed?	con	ailable prior to appletion of cause
l									of c	death?
L							1 🗆	Yes 2 No	1□	Yes 2□No
1	25. Was case referred to medicat axaminer?	Mana 's -t-					Deeth (Check only	one)		
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cer micanon.	27. Manner of Death 1 ■ Selectural 5 □ Pending	28a. Date of Inju	ay Year) 28	b. Time of Injury	28c. Inju	iry at ork?	28d. Describe	how injury occur	red	
	2 Accident investiga			М	10	Yes 2□No				
	3 Suicide 6 Could no determine	ad Zoe. Frace of in	jury - At home lc. (Specify)	, farm, street, fac	ctory, office		28f. Location City or T	(Street and Numi own, Stete)	ber or Rurai	l Route Number,
BOILD		Physician: To the best aminer: On the basis of	f examination							
	29b. Signature and title of Aliffor?	and manner st	ereu.	· · · · ·	29c, Licen	se number		29d. Date signe	d (Month)	Day Yearl
		///			Loo. LIGHT	oo mumbon				
	full				D20	6499		October	30,	2000
	30. Nama and authors of person wh	no completed cause of	death (Item 23	a) (Type, Print)						
	Ronald E. Mille	r M.D. #4 C	Culwell	Drive,	Mt.	Airy, M	aryland	21771		
9	31. Date filed (Month, Day, Year)	32. Registi	rar's Signature	4	1	0.41				
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State of Maryland / Department of Health and Mental Hygiene

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					Ce	rtificat	e of I	Death			Reg. No.		
		1. Decedent's Name (First, Middle	Last)							2. Date of Dec	ath		3. Time of Death
C.	Physician			John La	mb					Month October	Day 31	2000	4:10am
	/Medical	4a Facility Name (If not institution,	give street and nu		allio		14	b. City. To	wn, or L	ocation of Death		ty of Death	4.10am
1	Examiner			1110017									
		26304 Aiken Dr		7 1	80 6-1 de -0- 1	W Harder	1 Year	G_La If Under	rkst			Montgo	
	Funeral	The second second	6. Sex 1 1 M 2 I F	7. Age (In yrs.	rast oirtnoay) Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da	y, Year)	9. Birthp	place (State or Foreign ntry)
	Director	099-32-4074		68	113.					Dec. 5,	1931	E	ngland
	2 .	Usual Residence of Decedent 10s. State 10b. County		10c Cit	y, Town or Lo	nontion	-			_		1	Od Incido City Limite
	within 72 hours effer death with the Maryland ens. than "natural", or hems 23s or 28s-f show he was all Exemples must be notified a empleted by Funeral Director	Maryland Mo	ntgomery	10	arksbu				- "			·	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	or 2	10e. Street and Number				10f. Zip	Code				10g. Citizen of	What Cour	ntry?
	W 4 B	26304 Aiken Dri	ve				2	0871			E	nglano	đ
	r hems 23 does must	11. Marital Status		edent Ever in U,	S. 13.	Wes Dece			igin? (Sp	ecify Yes or No Rican, etc.)		ce - Americ	can Indian,
21215-0020	al', or he by Full	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed For 1 Tes If Yes, Gir Year or D	2 ⊠ No ve		n Yes, spe		Specify:		Hican, etc.)	Speci	eck, White, ify: Wh	etc. nite
Ò	ed within 72 hours ygiens. In then 'netural', It, the Medical E.	15. Decedent			16a. Dece	dent's Usu	al Occup	etion			16b. Kind of I		
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27	within the party of the party o	Elementary/Secondary (0-12)	College (1-40r 5+)		Bri	ckla	ver			Ma	sonrv	
0	EIDE	17. Father's Name (First, Middle, L	ast)			DIL	CKIU		er's Nam	e (First, Middle,			
Maryland	A P M												
2	should and Man umarks umarks	Frederick Lamb						Mari					
8	M 4 4	19a. Informant's Name/Relationsh								ral Route Numbe			
-		Bernice J. Lamb	/ Wife					rive,	Cla	arksburg	, Mary	land :	20871
970	2750	20a. Method of Disposition	34		lace of Dispo			se)	1	Dete	20c. Location	- City or To	own, State
Baltimore	y it is	1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (Sp		State					1	1/1/00	A 1	dand o	Winadada
₫	Demit. F Departme importan eny injur	21. Signature of Funeral Service L		riet		1 Lälli 2. Name ar				171700	Alexan	iria,	Virginia
38	Ede	21. Squarde di Fylina Sarvat	471	/					*	P. A. F	uneral	Home	
_	40200	sodel 0	Wxu	w						Damascus			20872
		23a. Part1. Enter the disease, or o shock, or heart tellure. List of	complications that of	saused the death	h. Do not en	ter the mod	le of dyin	g, such es	cardiac	or respiratory en	rrest,		Approximate Intervel Between
ec.	Physician	STOCK, OF HOSEL LONGING. LIST C	only one demos on e	JOCAT MINE.		^							Onset end Deeth
	/Medical	Immediate Cause (Final		0.10			00					1	2 10 40 1
	Examiner	disease or condition resulting in death)	2	0/41	1	Coli	10	_1					The 100.
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	certificate be executed ving physician and visa es the burial-transit	Sequentially list conditions,		Due to (o	r as a conse	quence of):							
68760,	man man	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	25,000										
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Division		4 Homicide	buildi	ng, etc. (Specif)	y)					City or Tox	vn, State)		
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State of Maryland / Department of Health and Mental Hygiene 0 0 3 6 2 0 9

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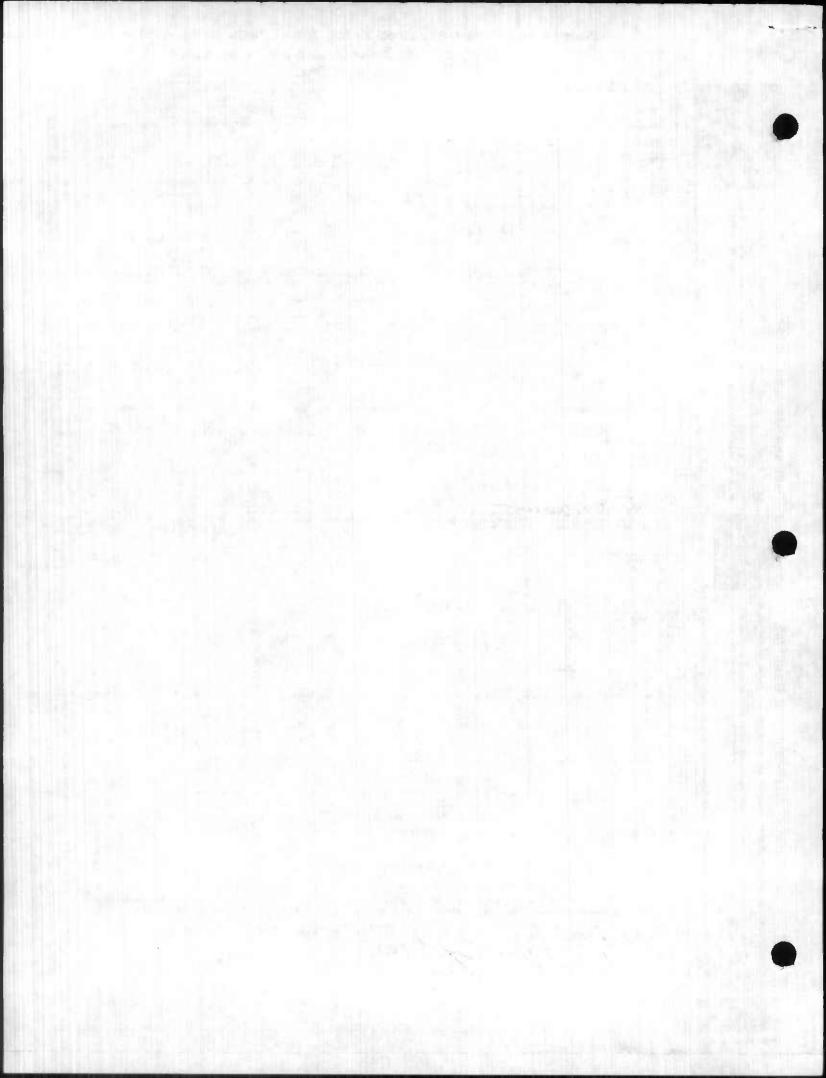
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Physician /Medical	SHELBY JEAN M	IOORE				OCTOBER	26 20	Year 000	6:40 PM
Examiner	4a Facility Name (If not Institution,	giva street and number	r)		4b. City, Town, or L	ocation of Death	4c. County of	of Deeth	
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show show sd.st	Usuel Residence of Decedent 10a, State 10b. County		10c. City, T	own or Location				100	d. Insida City Limit
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d 2 ahould be filed within 72 hours after death with and Mental Hygiens. 7 is marked other than "natural", or flering 23a treumatic event, the Medical Examiner must be treumated by Furneral I	11. Marifal Stafus 1 Never Merried 2 Merrie 3 Widowed 4 Divorced	12. Wes Deceden Armed Forcas 1 Tyes 2 to If Yes, Give Ayaar or Dafas	? No	13. Was Decedent of If Yes, specify C	of Hispanic Origin? (Sp Suban, Mexican, Puerto No Specify:	pecify Yes or No- p Rican, afc.)		- Amarice k, White, et WH]	tc.
ed within 72 ho yglens. ner then "natur it, the Medical. Completed	15. Decedent (Specify only highes Elementary/Secondery (0-12) 1 2			6a. Decedent's Usuel Oc (Give kind of work do life. DO NOT use re HATRDF	ne during most of wor lired)	king	6b. Kind of Bus	siness/Indu	ustry
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Mental H Mental H mile avan To Be	HERBERT C. TEA					Y BRANHA			
2 sho and a ma	19e. Informent's Name/Reletionsh	nip (Type, Print)		19b. Meiling Address (Str	eet end Number or Ru	rel Route Number,	City or Town, S	Stete, Zip C	Code)
and and a said	PAUL E. MOORE/H	USBAND		29402 HOWELI		TRAPPE,	MD 2167	3	
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pomit. Pages 1 a Department of Hea Important: If Iham any injury or othe STIGS.	21. Signature of Funaral Service L	icense II	CFSE	22. Name end Ad FELLOWS, I 200 S. HA	dress of Fecility HELFENBEIN ARRISON ST	& NEWNAM	FUNERA MD 2160	L HON	ME PA
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been sign should be		Marie P			178	24e. Was er perform	n eutopsy nad?	avai	re autopsy findings ilabla prior fo apletion of cause eath?
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or A lin b	4 Homicide determi	building, e	etc. (Specify)			City or Town	, Stete)		
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DHMH 16 Rev 6/95

Registrar

State of Maryland / Department of Health and Mental Hygiene

11					(Sertifica	ate of	Death			Reg. No.		
iniam	1. Decedent's Name	(First, Middle, L	ast)							2. Date of D Month	Day	Yeer	3. Time of Death
ician dical	Joseph	E	dward		Moor	e				Octob	er 18,	2000	9:15 PM
niner	4a Facility Neme (II	not institution, gi	ive street and n	umber)		-14		4b. City, To	own, or Le	ocation of Dea	th 4c. County	of Death	
	Potomac	Valley N	lursing	& Welli	ness	Center		Rock	kvill	le	Mor	ntgom	ery
al	5. Social Security N	umber 6.	Sex	7. Age (In yr	s. last birth		ier 1 Yeer	If Under Hours	24 Hrs. Min.	8. Dete of B	irth	9. Birthr	place (Stete or Foreign
or	185 24 3	892	1 M 2 □ F	67	Yı	s. Month	s Days	Hours	Mul.		5,1932		sylvania
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by	3 Widowed		If Yes, C	sive		1 Yes	2 № No	Specity.			Specif	y: Wh	nite
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9	17. Father's Name (F-715							e, Maiden Sumar		
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		Cremation 3 5 Other (Spec		n State		m Serv			. 1	oct. 19 2000		nesda	, MD
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	Immediate Cause (a.	Asp	irati	on Pne	umoni	ia				1	1 week
	resulting in death)			-		nsequenca o						1	
			h	Cer	ebra1	Vascu	lar A	Accide	ent				5 months
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/Medical													
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2													
no pindino										24a. Wa	is an autopsy formed?	24b. W	era autopsy findings vailable prior to
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5	1 Natural	5 Pending		e of Injury onth, Dey Year)	28b. Tir	ury	28c. Inju Wo			200. Describ	e how injury occu	nea	
Cat	2 Accident	investigation 6 Could not	ho -			М		Yes 2	JNO				
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S S													
	29a. Certifier (Check only	1M Certifying P	hyelcian: To the	na best of my ki	nowledge,	death occurr	ed at the ti	ma, date a	nd place,	and due to th	a causa(a) and m	anner as	stated.
edicai	one)	Z. L. Martinger E. K.		nnar stated.	mation and	or invastigati	ori, in my	opinion, de	atri occui	Ted et trie titlik	a, data and piaca.	SING GGO (to trie cause(s)
Ξ	29b. Signature and	title of cersifier	1.11	10	1	1 1	29c. Licen:	se number			29d. Date sign	ed (Month,	Day, Year)
	111	1001	TUK	1	40	(N)	I	001120)		Octo	ber 2	3, 2000
	30. Name and addre	asa of person who	completed ca	use of death (It	em 23a) (T	vpe, Print)	-						
	Walter E						. 511	ver (Sprin	ng. MD	20902		
0	31. Date filed (Mont		7	Registrar's Sig					PLII	-6, m	20702		
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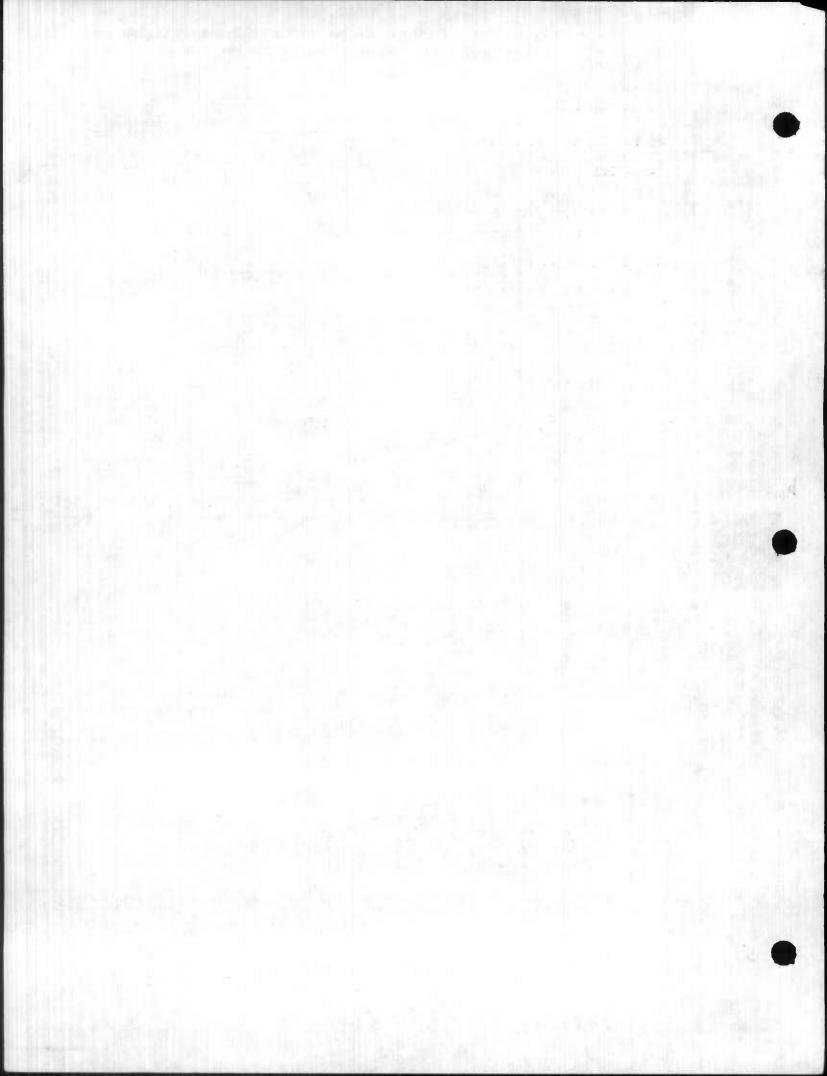


State of Maryland / Department of

f Health and Mental Hyg	iene 00 36211
of Death R	eg. No.

		Otate of Marylan		tificate of L			Reg. No.	U J	0211
	1. Decedent's Name (First, Middle, Last)					2. Date of Dea		Year	3. Time of Death
Physician /Medical	Theresa McClain					OCTOBE		000	12:42 AM
Examiner	4a Facility Name (If not institution, give s 6573 HILLMAR DI	Washington and the second seco		4	b. City, Town, or Lo Forestvi		4c. County Princ	of Death e Geo:	rges
Funeral Director	5. Social Security Number 6. Sex	7. Age (In yrs. 49	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Da) 8/30/	7 Year) 1951	9. Birthpla	ace (State or Foreign
3 8.	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Loc	ation				10	d. Inside City Limits
ch with the Maryla 23a or 28a-f shout be notified at ral Director	Maryland Prince G	eorges	restvil	10f, Zip Code			10g. Citizen of V	What Country	1 X Yes 2 No
23a or mat be or rai Oir	6573 Hillmar Dr.	#402		20747			United	Stat	es
21215-0020 a within 72 hours after death a piece. I than 'restural', or thems 23 the Medical Examiner must ompleted by Furneral	11. Maritat Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 Yes 2 YNo If Yes, Give Year or Dates:		/as Decedent of Hi Yes, specify Cuba ☐ Yes 2 ☐ No	ispanic Origin? (Spe n, Mexican, Puerto i Specify:	cify Yes or No- Rican, etc.)	Blac	a - America k, White, e Afro-	
21215-0 ed within 72 ho spiere, we than 'naturi t, the Medical.	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced	ent's Usual Occupa ind of work done of O NOT use retired	ation during most of worki	ng	16b. Kind of Bu	isiness/Indu	istry
within the Man	Elementery/Secondery (0-12)	College (1-4or 5+)			AGRICUL	TURE	GOVE	RNMENT	Γ
	17. Father's Neme (First, Middle, Last)			11-17-14	18. Mother's Name	(First, Middle,	Maiden Sumem	Θ)	
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Baltimore, semit. Pages 1 s Department of He mportant: If them iny injury or other once.	20a. Method of Disposition 1 X Buriat 2 Cremation 3 Re 4 Donation 5 Other (Specify)		emetery, crem	ition (Name of atory or other place emetery		Date ov. 4, 20(20c. Location -		
Balt permit, Departr Importa any inh ansy inh	21. Signature of Furieral Service License	1. Avolley	22.		FUNERAL I		MT RA	INTER	, MD 20712
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Examiner j	resulting in death) a.		cardi	uence of): omegaly				1	
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00 =	Ceuse (Disease or injury that initiated events resulting in death) Last		r as a consequ	ence of):					
dS, P.O. Box et iles that the death certification by the attending do be detected for use es d by Physician/Met	Part if. Other significant conditions cont	ributing to death but not res	uiting in the un	derlying cause giv	en in Part I.	23b. Dld 1	obacco uee co	ntribute to	the cause of death?
4 50 -						10	Yee 2□No	3 Prob	ably 4 Unknown
SCOr s been 2 shoul						24a. Was perfo	an autopsy med?	ava	re autopsy findings illable prior to npletion of cause leath?
The law page 2						10	res 2 No	10	Yes 2□ No
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Of Vita Physician: rhis certific ral director,	1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ 28a. Dete of Injury	ER/Outpatient		4 Unursing no	-	dence 6 Oth)
on oding th. The street of tune	1 Netural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	28c. Injun Wor M 1	k? Yes 2□No	200. 2000/100	iow injury coods		
Division of the or Attending P and Director: After ted in Director: After ted in by the funers Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre	et, factory, office		28f. Location (; City or Tox	Street and Numb vn, State)	per or Rural	Route Number,
Division o To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	29a. Certifier Check only 2 Medical Examinone)	cian: To the best of my knoer: On the basis of examine and manner stated.	wledge, death tion and/or inv	occurred at the tin estigetion, in my o	ne, date end plece, pinion, death occurr	and due to the ed at the time,	cause(s) and ma dete end place,	anner as sta and due to	sted. the cause(s)
To the comp	29b. Signature and title of certifier // // // // // // // // // // // // //	har min	Q,	29c. Licens MD2	5351		29d. Date signe 10/31		
	30. Name and address of person who cor 819 E CAPITOL S	npleted cause of death (Item Γ SE WASHI	n 23a) (Type, F NGTON	Print) D.C.	20003 DR	. Jay F	I. Choi		
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DHMH 16 Rev 6/95

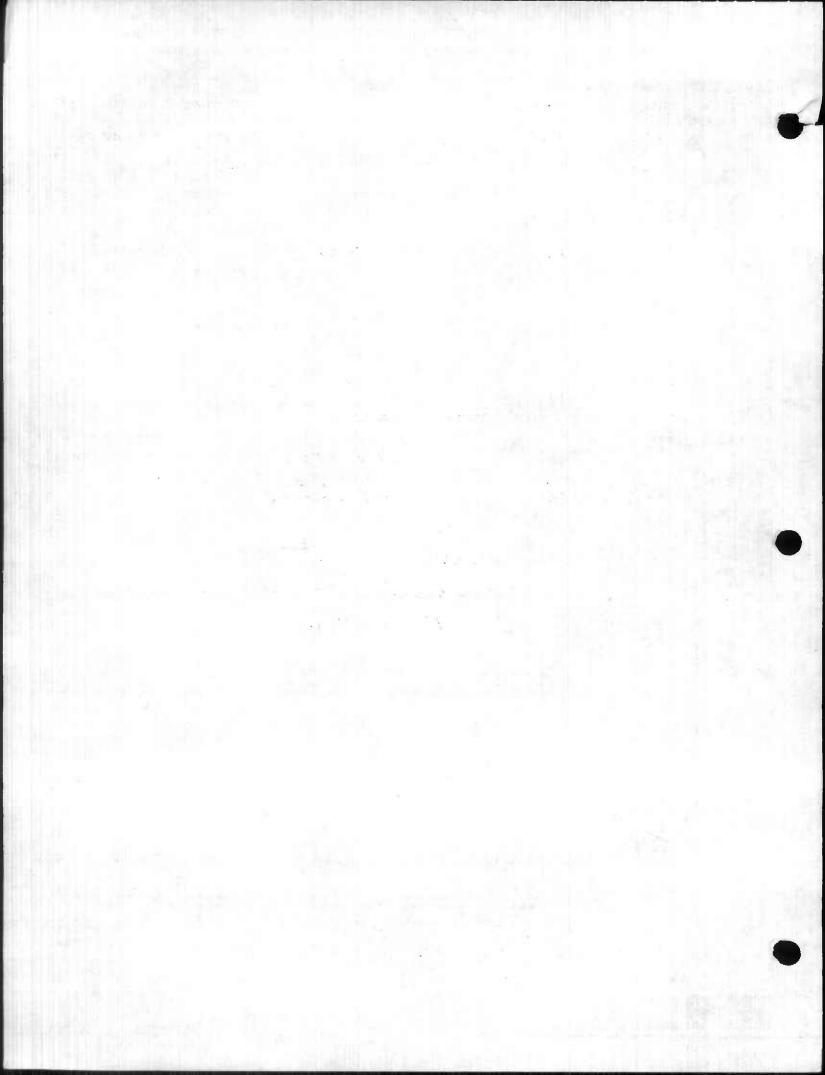


	1	I. Decedent's Nam	e (First, Middle, La	st)			Certificate of	, Dodin		2. Date of Deat	eg. No. h		3. Time of Death
Physician	1			thers						October	27, 2	OOO	4:30 A.
/Medical	4.		If not Institution, give		m <i>ber</i>)			4b. City, Tov		eation of Death	4c. County		
Examiner			enry Driv					Silve	er Sp	ring	Mon	tgome	ery
Funeral Director	5	Social Security N 258-05-7		ex □M 2] X]F	7. Age (In)	78. last birthe			Min.	8. Date of Birth (Month, Day, May 13,	Year) 1913	9. Birthp Cour Geor	place (State or Fore http), gia
	-	Jsuat Residence of IOa. State	Decedant 10b. County		100	City, Town o	or Location					1	Od. Inside City Lim
a or 28a-f show be notified at		Maryland	Montgome	erv	100.		r Spring						1 □ Yes 2√1
or 28a-f a	3	IOe. Street and Nur		1			10f. Zip Cod	le	-	11	Og. Citizen of	Whet Cour	ntry?
23a or unit be		2508 McH	enry Driv	ve			2090)4			United	Stat	es
Examiner must	5.0	11. Marital Status 1 Never Marri 3 XWidowed	ied 2 Married	12. Was Dec Armed Fo 1 Yas If Yes, Gi Yaar or D	orcas? 2√ No ve	n U,S.	13. Was Decedent If Yes, specify (gin? (Spe , Puerto F	cify Yes or No- lican, atc.)		ck, Whita,	
			15. Decedent's Ed	fucation		16a. D	ecedent's Usual Oc	cupation			16b. Kind of B	usiness/In	dustry
4, the Medical	hole	(Speci	oify only highast gra	College (ecedent's Usual Od Give kind of work do fe. DO NOT use re	na guring most tired)	or workin	9			
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		PINIT	Thew st	- Bra			Donald V						
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State Registrar 31. Date filed (Month, Day, Year) OCT 3 0 2800

32. Registrar's Signature

9. Sparks



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day October 25 **Physician** 2000 12:40 AM Marple Sutherland /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Doctor's Community Hospital Lanham Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 2♥ F 96 Yrs. 042 32 2772 Director Dec. 2, 1903 New York Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yas 2X No Mitchellville Directo Maryland Prince George's 23a or 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code must be 10450 Lottsford Rd. 20721 United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Maritef Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 8 Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: White Specify: à 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 89 Pages 1 and 2 should be nent of Health and Mental Josephine Bissicks William Bowles Sutherland Anna th and Man 7 is marke traumetic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a Sara Templeman / Daughter 1265 River Chase Lane, Charlottesville, VA 20b. Placa of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition Oct. 28 1 \$\times\$ Burial 2 □ Cremation 3 □ Removat from State 8 Columbus, OH Green Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2000 Rapp Funeral and Cremation Services Stephen D. Lohrmann P.A. 21. Signature of Funeral Supley tol 933 Gist Ave., Silver Spring, MD 20910 Approximate Interval Between Onset end Death 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. **Physician** tmmediate Cause (Final disease or condition resulting in death) /Medical Pneumonia 5 days Examiner Due to (or as a consequence of): Examiner Acute Cerebral Infarction 9 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Due to (or as e consequenca of): death certificate be axecut Box 68760. Physician/Medical Due to (or es a consequence of): 83 980 0 Part ff. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. detached The law requires that the 1 | Yee 2 No 3 | Probably 4 | Unknown 5 Parkinson's Disease signed be del Records. þ Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has page 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to medical 28. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 □ Nursing Home 5 □ Residenca 6 □ Other (Specify) Certification: To 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. fnjury at Work? 28d. Describe how injury occurred 28b. Time of After 5 Pending investigation 1 Natural Injury i after death.

I Director: Al 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a VTo the Funeral Completely filled Hospital 1th Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 25, 2000 D25079 H 30. Name and address of parson who completed cause of death (ttem 23a) (Type, Print) Don H. Yoblonowitz M.D., 7404 Executive Place #502; Lanham, MD 20706

DHMH 16 Rev 6/95

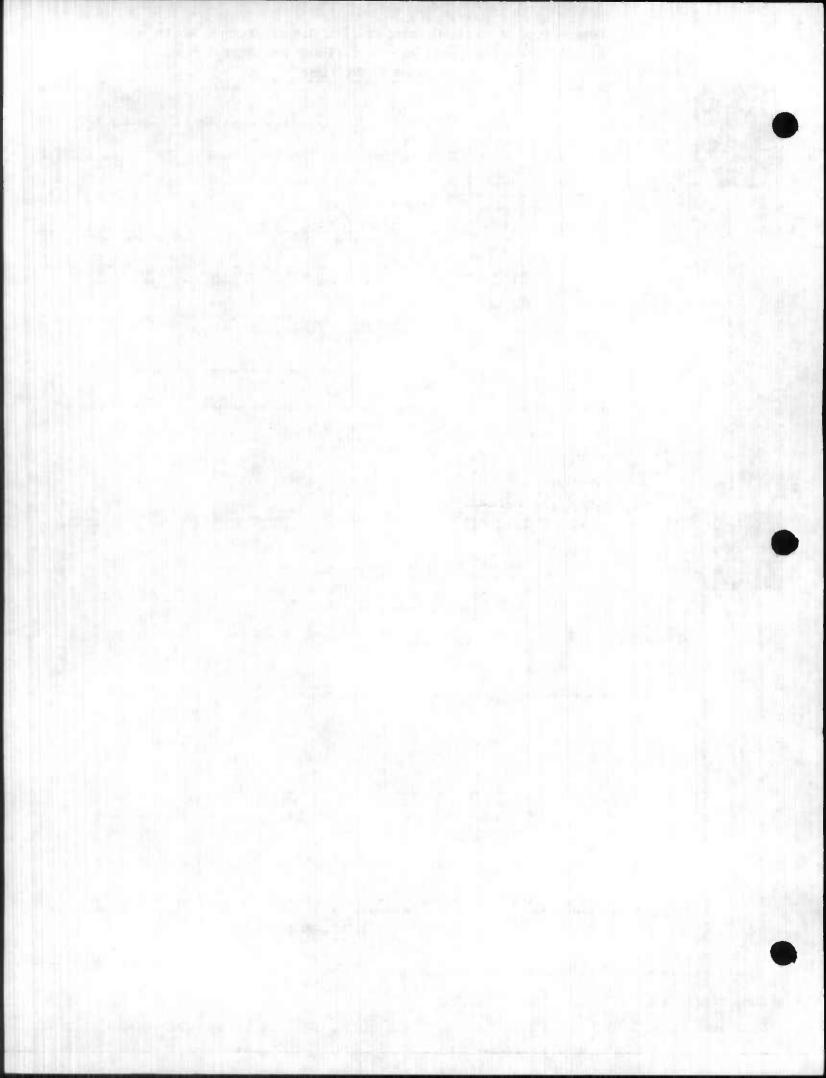
State

Registrar

31. Date filed (Month, Day, Year)

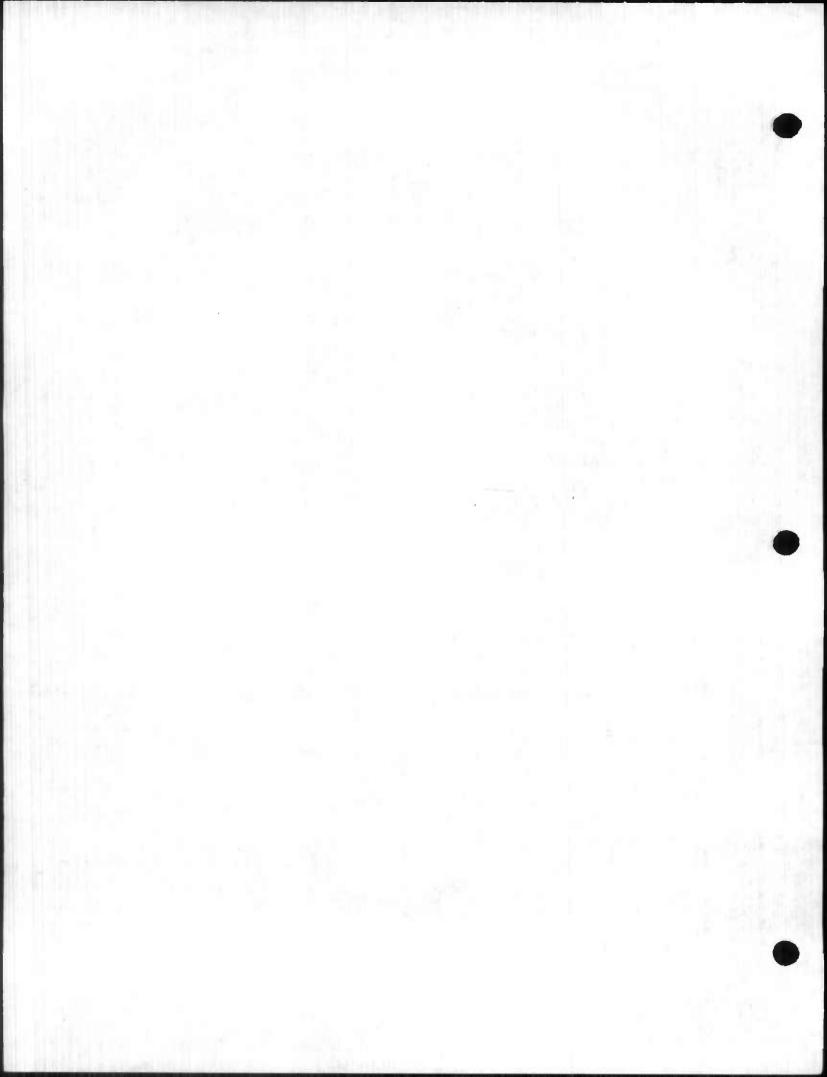
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32. Registrer's Signeture



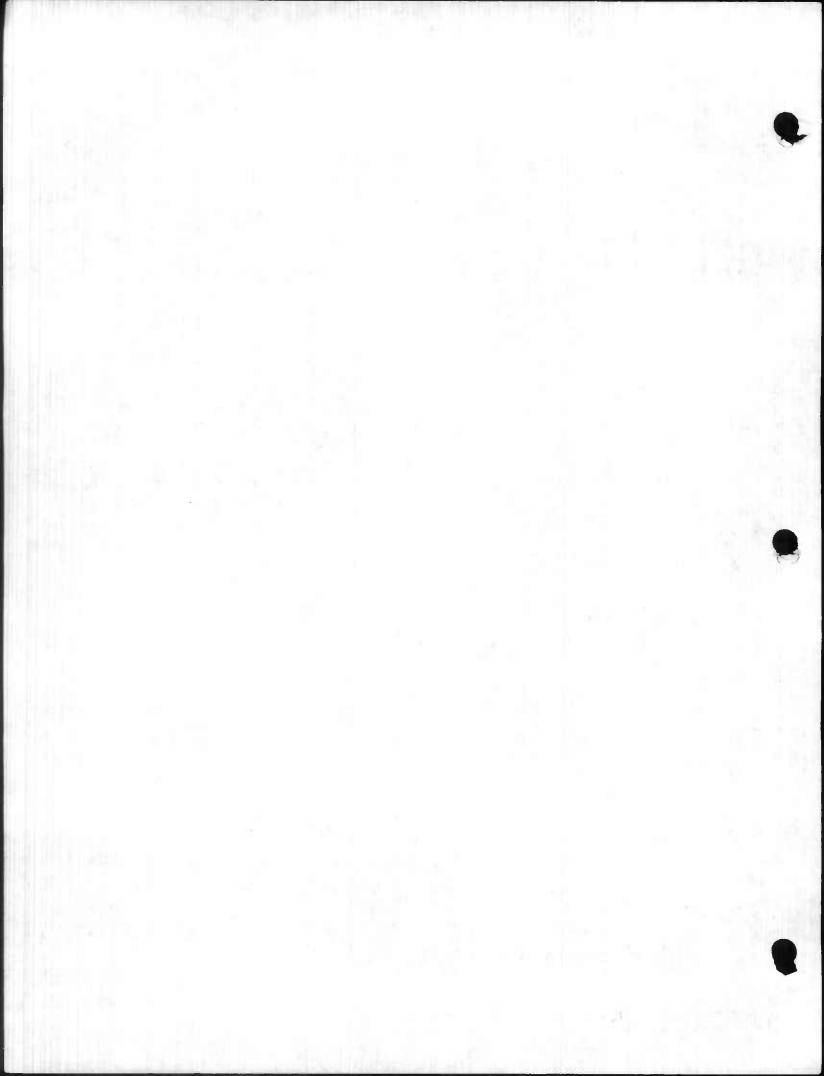
State of Maryland / Department of Health and Mental Hygiene 0 36214

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	Decedent's Nama (First, Middle, Last)	3-10-1		2. Date of Deet Month	h	3. Time of Death			
Physician /Medical	Marlon Robert An		7.00	OCTOBE		E. DECK CENTRE			
Examiner	4a Facility Name (If not institution, give street	t end number)		4b. City, Town, or Lo	cation of Death	4c. County of			
8	ROUTE #1 @ SUNNYSII	DE AVENUE		LAUREL		PRINCE GEORGE'S			
Funeral Director	5. Sociel Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Aga (In yrs. last bird	thday) If Under 1 Year Months Deys		8. Data of Birth (Month, Day, Oct. 12	Yaar)	9. Birthplace (State or Foreign Country) Jamaica		
D .	Usuel Residence of Decedant 10a, Stete 10b, County	10c. City, Towr	n or Location				10d. Inside City Limits		
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or 28a-f a	Maryland Prince Geor	ges Belts				Da. Citizen of Wh			
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a 23	11228 Cherry Hill Ro	ad, #204 Vas Decedent Ever in U.S.	2070		acifu Vaa or No-	Jamai	- Amaricen Indien,		
n / 2 hours after dearn with the maryland "naturel", or fiems 23s or 28s-f show edge Examiner must be notified at elected by Funeral Director	1⊠ Never Merried 2 Married	Armed Forces? MYes 2 - No I Yes, Give /ear or Detes: Unknown	13. Wes Decedent of If Yes, specify Cul		Rican, etc.)	Black	, White, etc. Black		
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or than		2	Maintenar	nce		Environ	mental Service		
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traum	19e. Informent's Neme/Retetlonship (Type, I	· ·	. Maiting Address (Street						
Health tem 27 other tr	Pamela R. Malcolm /		421 Bakersi Disposition (Name of ry, cremetory or other pl						
Department of H Important: If Net any Injury or oft pacs.	20e. Method of Disposition 1 Translate 2 Cremation 3 Translate 4 Donetion 5 Other (Special)		c. Location - City or Town, State urel, Maryland						
Departm Departm Importa any Inju	21. Signature of Funaral Service Learning	,	22. Nama and Add	ress of Fecility Hin	es-Rinal	di Fune	ral Home		
REFE	Am Ham	loth/	11800 Nev	Hampshir	e Avenue	0904			
Physician /Medical Examiner	tmmediate Ceuse (Finet disease or condition resulting in death)	Multiple I	consequence of):						
g physician and as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initialed events Due to (or es e consequence of): Due to (or as e consequence of):								
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certificate rector, pag	25. Was case referred to medical			26. Ptece of Deet					
his certification of director	examiner? 1 ☐ Yes 2 ☐ No Hosp	itel: 1 Inpatient 2 ER/Ou	utpatient 3 DOA	MAR			r (Specify) SCENE		
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iffe	all a state 6 Could not be	8e. Place of Injury - At home, fe			281 Location (Street and Number or Rural Route Number				
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Funer tely fill	(Check only 2 Medical Examiner:	n: To the best of my knowledge On the basis of exemination en- and mannar stated.							
To the comple	29b. Signeture and title of certifier		29c. Lice	nse number	2	9d. Date signed	(Month, Day, Year)		
40	No. Off	4.	0.0	.M.E.		OCTOBER	30,2000		
	30. Nema and address of pursuary who complete	eted cause of death (Item 23a)	(Type Print)						
	7 1/2 /2		111 Penn	Street, Ba	ltimore	, Maryla	and 21201		
	31. Date filed (Month, Day, Year)	32. Registrer's Signature	-			-			
State Registrar	MAY 0 3 2000	power 1	1. Sporks						
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	item 23a,b,c ptII,27 per me G790 12/19/00 yfCertificate of Death 1. Decedent's Name (First, Middle, Last)						alli	2. Date of Dec	3. Tima of Deeth				
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cal ner	4e Facility Neme (If	not institution of	Mary Ar		ynski		4b C	City, Town, or Lo	NOVEMB			20:15 PM	
١	W. W. Carrier												
١	5. Social Security Nu		CY HOSPITA		last birthdey)	If Under 1 Y	eer If	Lanhan Under 24 Hrs.	8. Date of Birti (Month, De)	PRINC			
	218-76-04.	39	1□ M 2X F	4	Ven	Months D	eys F	fours Min.	Apr. 24		Maryl	e (Stete or Foreign) and	
1	10a. Stete	10b. County		10c. Cit	y, Town or Loc	ation					10d.	Inside City Limits	
I	MD	Prince	George's	ge's Glenn Dale							XXYes 2□No		
MD Prince George's Glenn Dale 10e. Street and Number 10f. Zip Code						4		10g. Citizen of V	Vhat Country	?			
10117 Dubarry Street 11. Meritel Stetus 12. Wes Decedent Ever in U,S. 13. Wes Armed Forces? 12. Wes Decedent Ever in U,S. 13. Wes Armed Forces?						2076	59		USA				
11. Meritel Stetus 12. Never Merried 2 Merried 1			12. Wes Decede		,S. 13. V	Ves Decedent	of Hispe	nic Origin? (Spe Mexican, Puerto	ecify Yes or No-	14. Rac	e - American k. White, etc		
			1 Tes 2 If Yes, Give Yeer or Dete	Z¥No		1 ☐ Yes WNo Specify:			, 110011, 0101,	Specify: White			
		15. Decedent's E		cetion 16a. Deceder			ent's Usuel Occupation ind of work done during most of working			16b. Kind of Bu	usiness/Indus	try	
(Specify only highest grade Elementery/Secondary (0-12)			College (1-4)	or 5+)	life. C	OO NOT use re	NOT use retired)						
	12		Ø	Ø Sec							S Government		
	17. Father's Neme (/	First, Middle, Las	t)				18	. Mother's Neme	(First, Middle,	Maiden Sumem	19)		
I	Thomas .	Joseph M	ledynski		Helen F				Ropko				
ı	19e. informent's Ne	me/Reletionship	(Type, Print)		19b. Meilin	g Address (St	reet end	Number or Run	al Route Numbe	er, City or Town,	Stete, Zip Co	ode)	
	Helen Med	_	lother					Street,		Dale, MD			
ı	20e. Method of Dispo		Removel from Ste		Plece of Disposemetery, crem	sition (Neme of atory or other	of r place)		Dete	20c. Location -	City or Town	, Stete	
		5 ☐ Other (Spec			te of H	leaven	Ceme	etery 1	1/14/00	Silver	Sprin	ig, MD	
21. Signature of Funerel Service Licensee 22. Name and Address						Donaldson Funeral Home, P.A.							
23a. Pert 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock of heart failure. List only one cause on each line. Applications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, interest of the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, interest of the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, interest of the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, interest of the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, interest of the disease, or complications that caused the deeth.													
Tine		•	ALCOHOLISM										
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury the initiated events resulting in death) Last ALCOHOLISM b. Due to (or es a consequence of): C. Due to (or es e consequence of):													
. 1	thet initiated events resulting in death) L.		G	Due to (or es e consequence of):									
I			d								ì		
Part II. Other significant conditions contributing to death				ith but not resulting in the underlying ceuse given in Pert i.			n Pert i.	23b. Dld	tobacco uss co	ntributs to th	ne cause of death		
Part II. Other significant conditions of									10	Yes 2 No	3 Probal	bly 4 Unknow	
I										en eutopsy rmed?	evalle	autopsy findings able prior to eletion of ceuse	
ı									107	Yes 2□No	of de	ath? ∕es 2□ No	
	Are y						20	6. Plece of Deat					
	25. Was case referre	ed to medicel									or (Consite)		
	25. Was case referre		Hospitel:	atient 2 🖸	ER/Outpatien	t 3 DOA	Other:	4 Nursing Ho	me 5 Resid	dence 6 Oth	IN (Spacify)		
	examiner? 1 Ves 2 1 27. Menner of Death 1 Sheturel	No	28e. Dete of I		ER/Outpatien 28b. Time of Injury		injury at Work?	4 Nursing Ho		dence 6 Oth			
	examiner? 1 Ves 2 1	No 5 ☐ Pending	28e. Dete of I	njury Dey Year)	28b. Time of	28c.	injury at Work?		28d. Describe	now injury occur	red	Route Number,	
ical Certification: 10 be Completed	examiner? 1	5 Pending investigetic 6 Could not determined	28e. Plece of building.	njury Dey Year) Injury - At helc. (Specil	28b. Time of Injury ome, ferm, stri	28c. M eet, fectory, of	injury at Work? 1 Yes	s 2 □ No	28d. Describe 28f. Location (: City or Tou	Street end Numb wn, State)	red ber or Rural F anner es stat	ed.	
	examiner? 1 Yes 2 1 27. Menner of Death 1 80 Neturel 2 Accident 3 Suicide 4 Homicide 29e. Certifier (Check only one)	5 Pending investigetic 6 Could not determined	28e. Dete of I (Month, on be de building,	njury Dey Year) Injury - At helc. (Specilist of my knows of examine	28b. Time of Injury ome, ferm, stri	28c. M eet, fectory, of	injury at Work? 1 Yes	dete end plece,	28d. Describe 28f. Location (: City or Tou	Street end Number, State) cause(s) and middle and place,	oper or Rural F anner es stat and due to th	ed. ne ceuse(s)	
10 56	examiner? 1	5 Pending investigetic 6 Could not determined	28e. Dete of I (Month, on be d 28e. Piece of building, thysician: To the bestminer: On the bask	njury Dey Year) Injury - At helc. (Specilist of my knows of examine	28b. Time of Injury ome, ferm, stri	28c. M eet, fectory, of occurred at it restigation, in	injury at Work? 1 Yes	dete end plece,	28d. Describe 28f. Location (: City or Tou	Street end Numb wn, State)	ber or Rural F anner es state and due to the	ed. le ceuse(s)	
Certification: 10 De	examiner? 1 Yes 2 1 27. Menner of Death 1 Distermel 2 Accident 3 Suicide 4 Homicide 29e. Certifier (Check only one) 29b. Signeture and the	5 Pending investigetic 6 Could not determined. 1 Certifying P 2 Medical Examile of certifier ss of person who	28e. Dete of I (Month, on be d 28e. Piece of building, thysician: To the bestminer: On the bask	Injury Dey Year) Injury - At hetc. (Specification of examine steted.	28b. Time of Injury ome, ferm, stri y) owledge, deeth tition end/or inv	occurred at the estigation, in 29c. Li	injury at Work? 1 Yes fice he time, my opini	dete end plece, on, deeth occurr	28f. Location (: City or To: end due to the red et the time,	Street end Number, Stete) cause(s) and middle and place, 29d. Dete signe	anner es stat and due to the d (Month, De ER 11,	ed. le ceuse(s)	

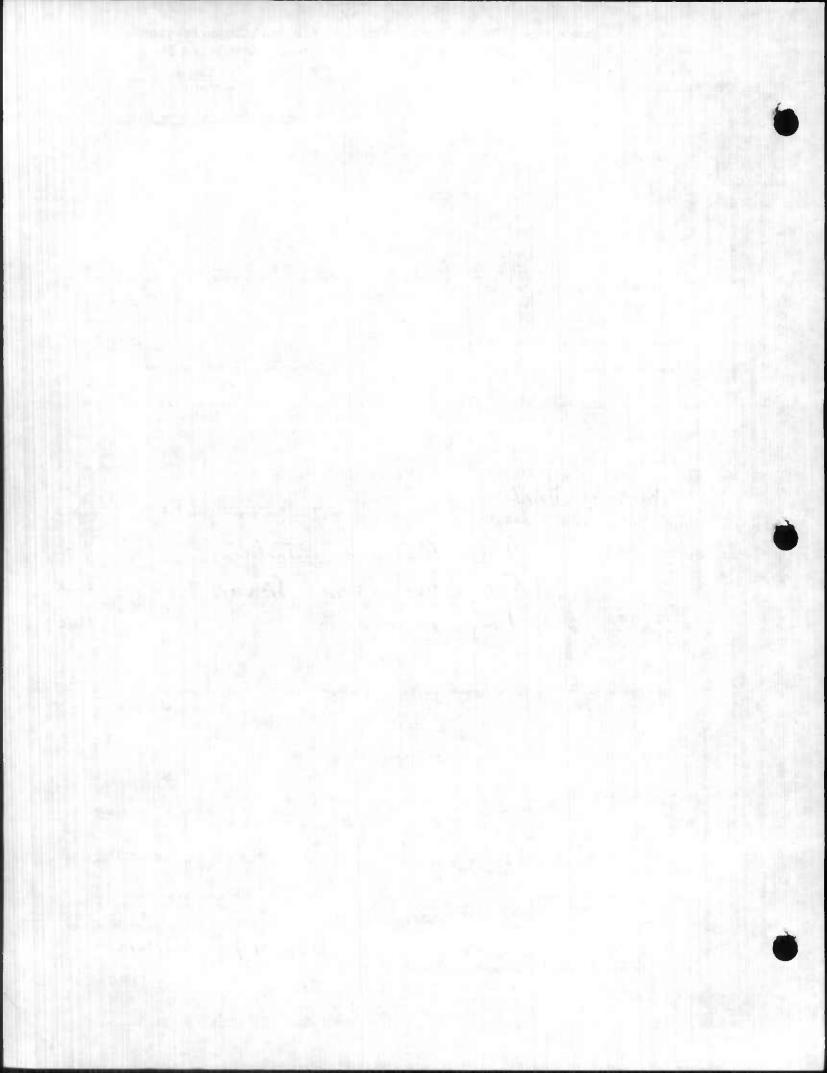


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

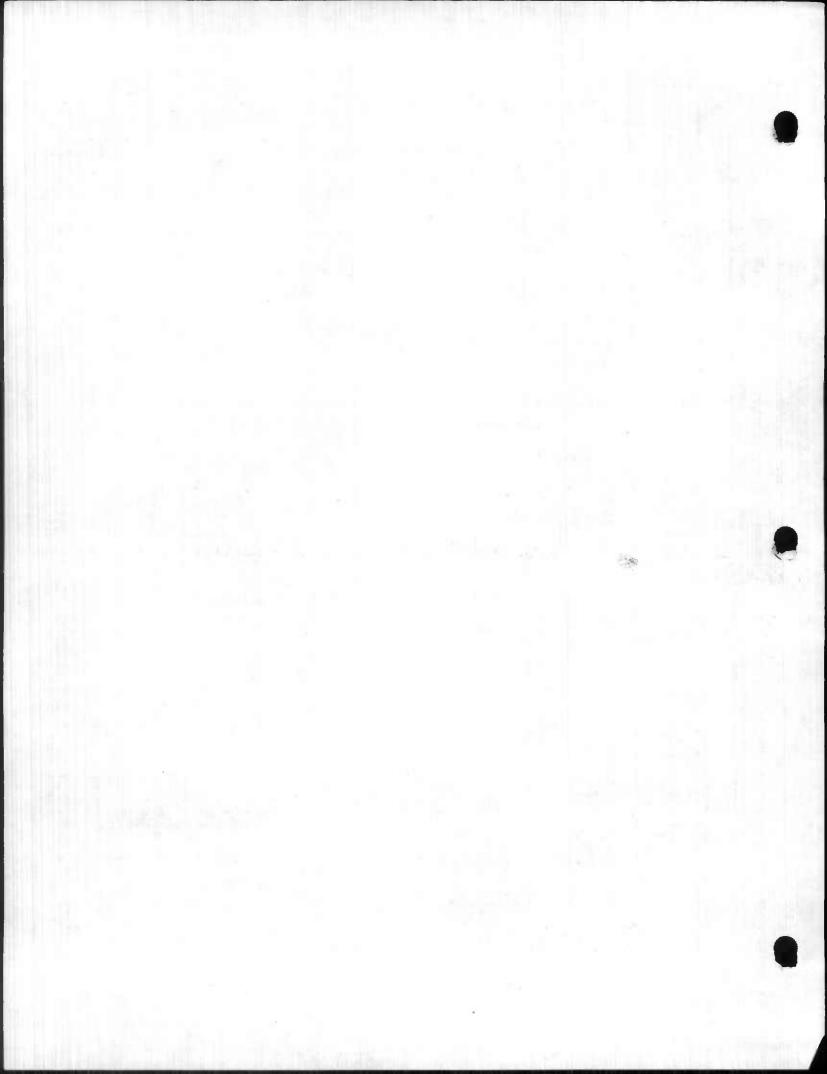
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	Decedent's Name (First, Middle, Last)						2. Date of Death 3. Time of Death				
Physician							Month	Day	Year		
/Medical	Agnes Victoria McClain						October	, ,	2000 6:20 A.M.		
Examiner	4a Facility Name (If not institution, give		-i+-1		1	4b. City, Town, or L					
	Frederick Mem		_	1 941 4		Freder		Frederick			
Funeral Director	5. Social Security Number 6. Se 218–48–3702		99)	(rs. Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June II, 1901 9. Birthplace (St. Country) Mary			Ace (State or Foreign Maryland	
g .	Usual Residence of Decedent		10a City Tour	or Longtion							
athon and a	10a. State 10b. County		10c. City, Town						10	d. Inside City Limits 1 Yes 2 No	
20 1 after death with the Ma or Herre 23e or 28e-1 a aminer must be notifies y Furneral Director	Maryland Frede	rick		Monrovia							
	10a. Street and Number 4420 Ed McClai	n Road	10f. Zlp Code 217				0g. Citizen of Wi	U.S.			
	11. Marital Status 1 Never Married 2 Married	Ever in U.S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 \(\text{Yes} \) 2 \(\text{No} \) No Specify:			an, Mexican, Puerto	pecify Yes or No- Rican, etc.)		- America , White, e			
DOOZ Numit.	3 ₩ Widowed 4 Divorced	Yeer or Detes:	1.00		10			tot Kind of Dun			
1 21215-0020 ed within 72 hours al yogen of wer than "natural", or At the Medical Exam Completed by I	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	16a. Decedent's Usual Occupation (Give kind of work done during most of work iffe. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home						
2 2 2 2 1	27 Eathara Nama /First Middle Loott		П	meniake		19 Mather's Nom	o (First Middle 1			3	
yland build be file Mental Hy mised other file event	17. Father's Name (First, Middle, Last) John Fink				ie Elsro	n, Middle, Malden Sumame) Elsroad					
Mary nd 2 sho 27 is me r treume	19a. Informant's Name/Relationship (7) Donald E. McClai	rpe, Print) .n/Son				and Number or Ru 33, Monro				Code)	
timore, Pages 1 a tment of He tent: If hem dury or othe	20a. Method of Disposition 1										
Balti permit. Departm importa eny tribu	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney & Basford Funeral Home										
	23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest.										
Dissolution	shock, or heart failure. List only or	ne cause on each lin	10.							tnterval Between Onset and Death	
Physician /Medical	thmediate Cause (Final disease or condition resulting in death) ACUTE Myocardial Tart Due to (or es e consequence of): Cowgeshue Hzpar FA										
Examiner								~		1 cery	
-		Can	Due to (or es e o	onsequence of)	:	5				1 10	
nsit fed						T 1A	lune			1 cuc	
ovecuted in and instransit										1,	
68760, ifficete be ex g physician as the burial										/ulc	
certificate be dding physicia use as the but	resulting in death) Last Oue to (or as e consequence of):										
SOX 6											
Bo ath c ath c in us											
O. I.	Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco usa contributa to the cause of death?				
thet the death and by the attended for y Physicial								1 ☐ Yea 2 € No 3 ☐ Probably 4 ☐ Unknown			
IS, Parest thet signed to be det											
v requir							performed?			re autopsy findings ilable prior to apletion of cause leath?	
I Re lav The lav page 2							1 🗆 Y	s 200 No	10	Yes 2□ No	
Vital Indiction: The certificate rector, page Co	25. Was case referred to medical					26 Place of Dee	th (Check only on				
Vita	axaminer?	Hospital: 1 Anpatie	ni 2□ ER/Out	patient 3 D	Oth Oth	Ari			. /Panik	4	
of Vita Physicien: this certific and director,	27. Manner of Death	4 Li Nursing H	ursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred								
After fune	1 ☐Natural 5 ☐ Pending										
Attending and death. ector: After fune by the fune	2 Accident investigation 3 Suicide 6 Could not be				103 2 110						
Division of Vital or Attending Physicien: The effect death. Director: After this certificate director, particular director, partification: To Be CC entification: To Be CC	4 Homicide 4 Homicide 4 Homicide 4 See Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)						City or Town		or Hotal	riodie rember,	
Dipltal or ours efter or filled in											
Division (Pe Hospital or Attending P n 24 hours eiter destructions: As the transment Direction: After transment bit on by the funering tilled in by the funering edical Certification:		sician: To the best oner: On the basis of	examination and								
To the Hospital of within 24 hours of To the Funeral D completely filled is											
5 1 1 5 8 T	0 0 0 /										
	del	COW.	2			D 366 4	19	10/16	100		
100	30. Name and address of person who co									1 01700	
	Edward Riul	i, M.D.,	180 Thom	nas Johr	nson	Dr., Sui	te 202,	Frederi	ck, M	id. 21/02	
State	31. Dete filed (Month, Day, Year)	32. Registra	r's Signature	1.	1						



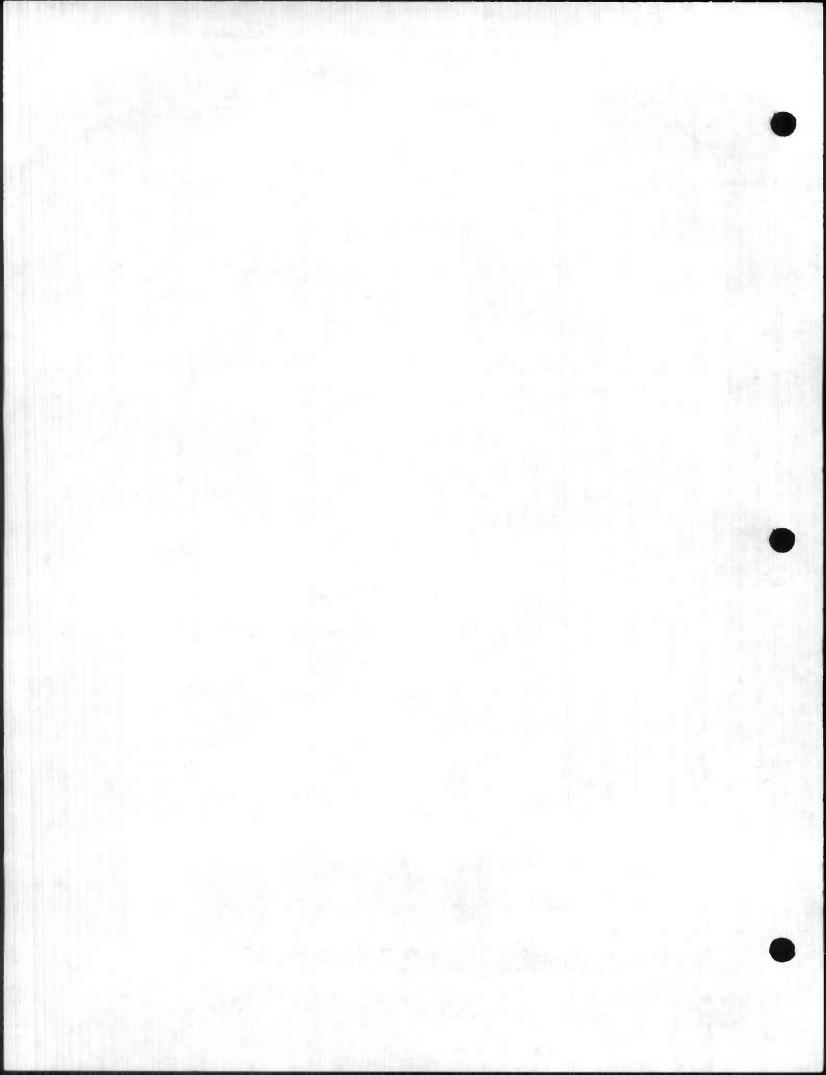
State of Maryland / Department of Health and Mental Hygiene 0 0 3621

_	Decedent's Nama (First, Middle, Last))	Cert	tificate of	Death	2. Dete of Deet			ne of Death	
Physician	Mary Virgin	ia Maher				October	Dey 16 20	Yaer 000 1:3	30pm	
/Medical Examiner	4a Fscility Nama (If not institution, give				4b. City, Town, or L		4c. County		орш	
LXammer	11514 Weller Road				Monrov	ri a	F	ederick		
Funeral	5. Social Security Number 6. Se		last birthday)	If Under 1 Year					ate or Foreign	
Funeral Director		DM 213€F 79	Yrs.	Months Deys	Hours Min.	8. Dete of Birth (Month, Day, April 7	, 1921	Birthplace (State or Foreig Country) Virginia		
h the Maryland r 28a-f show undfilled at frector	10a. Stete 10b. County		ity, Town or Loc					de City Limits		
or 28e-fr be notified	Maryland Frederi	ck	Monrov	7						
1 0 D	10a. Street and Number 11514 Weller Roa	d	10f. Zip Code 21770				0g. Citizen of W	U.S.A.		
hours after death with the transition of thems 23s. It Examiner must be done by Funeral E	11. Meritel Stetus 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forcas? 1 Yas 2 No If Yes, Give Year or Detes:		les Decedent of H Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yas or No- Rican, etc.)		- American Indian k, White, etc. White	n.	
od within 72 ho or ypiene. we than "naturn t, the Medical. Completed	15. Decedent's Edu (Specify only highest grad	e completed)	16a. Decede (Give k life. De	ent's Usuel Occup ind of work done O NOT use retire	pation during most of world)	king	16b. Kind of Bu	siness/Industry		
ad with hygiene. Wer the M	Elementery/Secondary (0-12) 7 th	College (1-4or 5+)		memaker				home		
Marry Hand A 1 A 15-00 Code of a should be fised within 72 hours at the and Marriar Hypiers. The marked other than "natural", or treumstic event, the Medical Exam To Be Completed by F	17. Father's Nema (First, Middle, Last) Stewart Repa	SS				e (First, Middle, M Asbury	Meiden Sumam	9)		
show and N	19e. Informent's Neme/Reletionship (Ty	rpe, Print)	19b. Meiling	Address (Street	and Number or Ru	ral Route Number,	City or Town,	Stete, Zip Code)		
27 th	Thomas F. Maher, S	r Husband	11514	Weller	Road, Mo	nrovia l	Marulan	a 21770		
a Hand	20a. Method of Disposition	20b.	Place of Dispos	ition (Neme of etory or other ple	Road, No.			City or Town, Stet		
namit. Pages 1 a Department of He mportant: If Nem iny Injury or other	1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	TOTAL TOTAL STORE	unt Oli	vet Ceme	etery	10/20/00	Frede	rick, Ma	ryland	
Department of the control of the con	21. Signetura of Foneral Service License	Une	01		lesworth lesworth e Road, I				72	
Physician /Medical Examiner	23a. Part1. Entar the disease, or complished, or heart feilure. List only of Immediate Cause (Finel disease or condition resulting in death)	METASPATIC		Mora				Onset a	Between and Death	
tificate be associted as the burist-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of):									
seth certificate be ax attending physician for use as the buriel Sian/Medical E.	resulting in death) Last									
death cer e attendir ed for use	Dat II Other steel Man A and distance	A-15- A1 A A A A		4 4 1	. 6	l one Dida-				
that the death cert ed by the attending detached for use Physician/M	Pert II. Other significant conditions con	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause						ontribute to the cause of death? 3 Probably 4 Unknown		
requires been sign should be		9				24a. Wes el perform	n eutopsy ned?	24b. Were autop available pi completion of death?	rior to	
The law ate has page 2						1 □ Ye	s altho		alz/No	
certificate irector, pag	25. Was case referred to medical				26. Place of Dee	th (Check only on	/		,	
Physician: this certific ral director.	examiner?	lospitel:	ER/Outpatient	3 DOA Of		ome SE Reside		r (Specify)	SHILL	
ding Phys h. After this funeral di	27. Manner of Death Death Pending	28a. Date of Injury (Month, Day Year)	26b. Time of Injury	28c. Inju		28d. Describe ho				
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be (2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Plece of Injury - At h building, etc. (Speci	ome, ferm, streety)			281. Location (St. City or Town		er or Rurel Route i	Number,	
To the Hospital within 24 hours a To the Funeral Completely filled Medical Ce	29e. Certifier (Check only one) Certifying Physical Examination	sician: To the best of my knoter: On the basis of examing and manner steted.	owledge, deeth outline and/or investigation	occurred et the ti estigetion, in my o	me, dale and plece, ppinion, deeth occur	end due to the ce red et the time, da	euse(s) end me ate end piece, a	nner as stated. and due to the cau	use(s)	
within 3	29b. Signeture and title of certifier /	and marrier steleti.		29c. Licens	se number	20	9d. Data sinned	(Month, Day, Yea	er)	
D. 3 T. 9	* Morellow	sing Mo			761	23	10/17	,	***	
	30. Name and address of person who co				T1		, 217	0.1		
	Brian M. O'Conne 31. Dete filed (Month, Day, Year)	32. Registrar's Signal	st /th	street,	rrederic	k, Maryl	and 21/	OI		



State of Maryland / Department of Health and Mental Hygiene 3 6 2 1 8

		Ce	rtificate	of L	Death		Reg. No.	0. 0	U Lm 1 U	
1. Decedent's Name (First, Middle, I						2. Date of De Month	eath Day	Year	3. Time of Dea	ath
Evelyn S	Mil]	ls				Octobe		2000	11:31	AM
at 4a Facility Name (If not institution, g	ive street end number)			4	b. City, Town, or					1 N.1
Frederick Memori	al Hospital			F	rederick		Fre	derick		
		rs. last birthday)	If Under 1	Yeer	If Under 24 Hrs	8. Date of Bir			nplace (Stete or Fountry)	oreign
216-60-7777 Usual Residence of Decedent	1□M 20F	86 Yrs.	Months I	Days	Hours Min.	Dec. 1	6, 191			
10a. State 10b. County	10c. (City, Town or Lo	ocation						10d. fnside City L	imits
Maryland Frederi	ok A	damstow	n						1 Yes 2	Q No
10a, Street and Number	.CK A	uailistowi	10f. Zip C	ode			10g. Citizen	of What Cou	untry?	
Maryland Frederi 10a. Street and Number 2507 New Design 11. Manital Stetus 1 Never Married 2 Married	Road		217			W 77%	USA			
11. Marital Stetus	12. Was Decedent Ever in	U.S. 13.			spanic Origin? (S n, Mexican, Puer	Specify Yes or No		Raca - Amer	ican Indian,	
1 Never Married 2 Married 3 MWidowed 4 Divorced	Armed Forces?		ff Yes, specify 1 ☐ Yes 2 Ç			to Rican, etc.)		Black, White		
		16a Dece	ident's Usual (Occups	ation		16b Kind o	Whi of Business/I		
(Specify only highest (rade completed)	(Give	kind of work DO NOT use	done d	furing most of wo	rking				
Elementary/Secondary (0-12)	College (1-4or 5+)	self					farmi	ng S. h	nomemaker	_
17. Father's Neme (First, Middle, La	st)	PETT			18. Mother's Na	me (First, Middle			iomemaket	
77 1 1 2										
		40h 84e20	ino Address /	Mary Frances Simms Address (Street end Number or Rural Route Number, City or					in Code)	
19a. Informant's Name/Relationship)
John S. Mills, s		2007			gn Road,	Adamst		aryLan ion - City or 1		
1X Buriel 2 Cremetion 3 4 Donation 5 Other (Special Control of the	Removal from State D	resbyte:	metory or other	er pleci	ch Cem.	11/3/2000			Marylan	nd
21. Signeture of Tuneral Service Lic 23a. Part 1. Enter the disease, or co shock, or heart failure. List on	De_ MO	0999 10	2. Name and O6 East	t Cl	hurch St	reet, F	rederi		Ouneral H 21701 Approximate Interval Between Onset and Dea	en
Immediate Cause (Final disease or condition resulting in death)	a. Congest	O (or as a conse	PART equence of):	- 6	FAILURE			1	2 hou	10
2	CORONA								UNKNOU	ب يہ
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying	Due to	o (or as e conse	quenca of):					1		
	ARTERIUS	CLEROTI	ic Ca	-20	iu - UASC	ular o	lisea	33	UNKNO	LW
resulting in death) Last Due to (or as a consequenca of):										
\$	d	-						1		
Part II. Other significant conditions	contributing to death but not re	resulting in the	underlying cau	use aive	en in Pert I.	23b. Dic	tobacco use	contribute	to the cause of d	leath?
Phys			, , ,						robably 4 12 Un	
Completed by						24a. Wa	s an autopsy ormed?	8	Were autopsy tind available prior to completion of caus of death?	
5						10	Yes 201	No 1	1 ☐ Yes 2 ☐ No	
					28 Place of Do	ath (Check only				
25. Wes case referred to medical examiner? 1 Yes 28 No	Hospital: 1 Inpatient 2	☑ ER/Outpatie	of 20 DO4	Oth	or.	Home 5□ Res		Other /Soo	cify)	
	28a. Date of Injury	28b. Time (28d. Describe			ony/	
1 Natural 5 Pending 2 Accident Investige	ion (Month, Dey Year,		М	C. Injun Worl	k? Yes 2□No					
3 Suicide 6 Could no 4 Homicide determine	28e. Place of Injury - A building, etc. (Spe		treet, fectory,	offica			(Street end A own, Stete)	rum <i>ber</i> or Ru	ure! Route Number	τ,
29a. Certifier 1 Certifying	Phyelcian: To the best of my k aminer: On the basis of exam and menner stated.									
29b. Signature and title of cartifier			29c.	License	e number		29d. Date s	igned (Monti	h, Day, Year)	
100.11	· A 1.	> VP	40	7	1058	7	11/	2/2	000	
Jerry (,)	min /7.1		Dain)		1-000	202.0- 1	ch alia	5 100	SC	
			(, Print)	~	1/120	CACOA A	THE PAIN	- 14c	0 7	
		4	CU AH	7-1711	U -	168 0816 16	1, 1	10	11 101	
30. Name and address of person with Credition 1. Shirth 31. Date filed (Month, Day, Year)	o completed cause of death (I	PRES hi	ED AFI	FAIR	1058 FREC Ur F	REDERIC	CK, A	10 140	2170	21



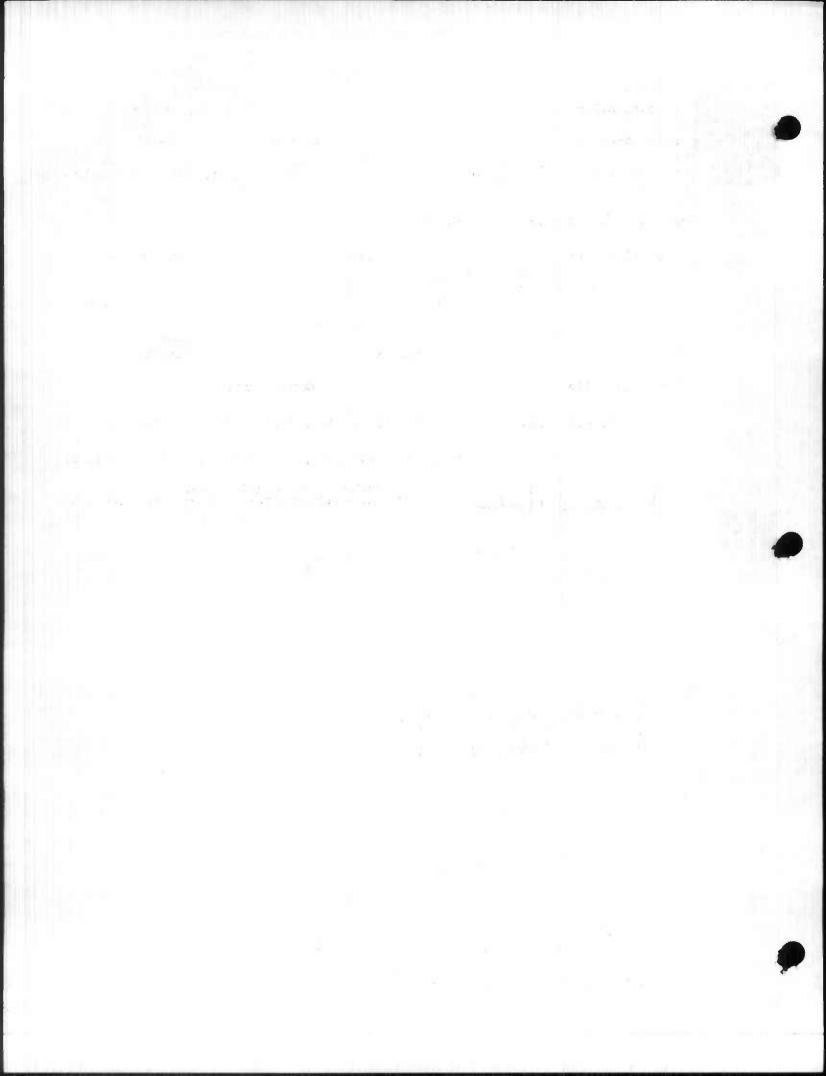
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 26, 2000 **Physician** Vincent Miller 1415 October /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Union Hospital Elkton Cecil. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthpiece (State or Foreign Country) **Funeral** 11 M 2□ F Yrs. Director 711-07-6784 74 DEC 1, 1925 Pennsyl.vania Usuel Residence of Decaden the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow traumatic event, the Madical Examiner must be notified at 1 X Yes 2 No Director Pennsylvania Chester Oxford 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? ò 309 Valley Road items 23a 19363 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Wor 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bieck, White, etc. 11. Marifai Stetus 1 XYes 2 No War Yeer or Detes: should be filled within 72 hours after ond Mantal Hygiena. merked other than "natural", or iter 1 ☐ Never Merried 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Steel Elementery/Secondery (0-12) Coilege (1-4or 5+) Security Manufacturer 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Peges 1 and 2 should be Depertment of Health and Mantall Important: If Nem 27 is marked of any injury or other traumatic eve once. Lawrence Miller Naomi Jones 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Luvenia A. Miller/Wife 309 Valley Road, Oxford, Pennsylvania 19363 20e. Method of Disposition 20b. Plece of Disposition (Neme of cametery, cremetory or other placa) 20c. Location - City or Town, Stete 1 ☐ Burial 2 【XCremetion 3 ☐ Removal from Stete 10/27/00 West Chester, PA R.A. Ferris & Co. Inc. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerei Service Licansee 22. Name end Address of Fecility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 eles a 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical immediate Cause (Finei diseese or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner pital or Attending Physician: The law requires that the death certificate be executed ours effer death.

evel birector: After this cartificate has been signed by the attending physician and filled in by the intensal director, page 2 should be deteched for use as the bunkel-transit filled in by the intensal director, page 2 should be deteched for use as the bunkel-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lesf Due to (or es e consequence of): P.O. Box 68760, Physician/Medical Due to (or es e consequence of): Pert if. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Dementia of Alzheimers Type 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ - Coronary Artery Disease 24b. Were autopsy findings eveilable prior to completion of cause ot death? Completed 24e. Wes an eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 28. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28e. Dete of Injury (Month, Dey Year) 27. Menger of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 1 Neturei 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide within 24 hours e To the Funeral C completely filled 1 Cartifying Phyeician: To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the bests of exeminetion end/or investigation, in my opinion, death occurred et the time, date end pieca, and due to the cause(s) end menner steted. 29a. Certifier Medical To the 29b. Signature end titie 2f certifier 29c. License number 29d. Dete signed (Month, Dey, Yeer) 023322 10.27.00 Jackelin SMD 30. Name end eddress of parson who completed cause of deeth (Item 23e) (Type, Print) 1 VA SUITE SB, Elkin MD21921. S.S. SACHDEN MD, 118 NORTH ST 32. Registrer's Signeture 31. Dete filed (Month, Dey, Year) State

DHMH 16 Ray 6/95

Registrar

OCT 3 0 2000



Please

Please		rint In Black In Maryland / Depa		Health	and N	Mental Hyg	70	ible.	3622	0
1. Decedent's Name (First, Middle, I	.est) VABB					2. Date of Dee Month Octob	th Dey	Year 2000	3. Time of De	
4a. Facility Neme (If not institution, g 3 Pine Row	ive street end numb	er)		4b. City, To Warv		ocation of Deeth	4c. Count	y of Death i I		
5. Sociel Security Number 6. 220 – 20 – 61 0 4	Sex 7. 1 □ M 2 🔀 F	Age (In yrs. lest birthdey) 72 Yrs.	If Under 1 Yes Months Dey		24 Hrs. Min.	6. Dete of Birth (Month, Dey 9-16-1	Year) 928		elece (State or F etry) vland	oreign
Usuel Residence of Decedent										
Maryland Cec	il	10c. City, Town or Lo						1	0d. Inside City	
10e. Street and Number P.O. BOX 47	3 Pine	Row	101. Zip Code 2 1 9 1	2		,	log. Citizen of US Z		ntry?	
11. Marital Status 1 ☐ Never Merried 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Wes Decede Armed Force 1 Yes 24 If Yes, Give Yeer or Dete	s? ☐ No	Wes Decedent of If Yes, specify Co 1 ☐ Yes 2 N	uben, Mexica	n, Puerto	ecify Yes or No- Rican, etc.)	Ble	ce - Americ eck, White, fy: whi	etc.	

Funeral Director

Physician

/Medical

Examiner

with the Meryland

ortant: if item 27 is marked other than "natural", or items 23s or 28e-f show injury or other traumstic event, the Medical Examinar must be notified at permit. Peges 1 and 2 should be filed within 72 hours after deeth Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic avent

Baltimore, Maryland 21215-0020

Physician /Medical **Examiner**

signed by the attending physician end I be detached for use as the burial-transit page 2 certificate hes Attending Physician: After this funeral

Division of Vital Records, P.O. Box 68760

To the Hospital or Attendir within 24 hours effer death. To the Funeral Director: Al completely filled in by the

Examiner Physician/Medical p Completed Be Certification: To Medical

23a. Part1. Enter the disease, shock, or heart failure. Id.

1 Yes 2XNo

5 Pending

27. Menner of Deeth

1 Neturel

2 Accident

4 Homicide

Dr. Delboy

31. Dete flied (Month, Dey, Year)
OCT 3 1 2000

3 Suicide

11. Marital Status 1 ☐ Never Merried 2X Married 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) 1 2 17. Fether's Neme (First, Middle, Last) Julian Tyler 19e. Informent's Neme/Reletionship (Type, Print) Fred Nabb 20e. Method of Disposition 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

Director

þ

Completed

Be

2

19b. Melling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) P.O. BOX 47, Warwick, Md. 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) Townsend Cemetery

Homemaker

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)

20c. Location - City or Town, Stete Dete 11-2-00 Townsend, De.

22. Name and Address of Facility
DANIELS & HUTCHISON FUNERAL HOME 212 N. Broad st., Middletown, 19709 DE. is that caused the deeth. Do not enter the mode of dying, euch es cardiec or respiretory errest, Approximate Interval Between Onset and Deeth

18. Mother's Name (First, Middle, Melden Sumeme)

Marjorie

Immediate Cause (Final disease or condition resulting In deeth) adenocarinoma metastatic Cancer Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest MAGNIC Due to (or es e consequence of)

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Type II, High cholestero Subdural hemotoma

College (1-4or 5+)

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an eutopsy performed?

30

00

1 Yes 2 No

16b. Kind of Business/Industry

Domestic

Dawkins

1 Yes 2 No 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one)

Hospitel: 1 | Inpatient 2 | ER/Outpatlent 3 | DOA Other: 4□ Nursing Home 5√ Residence 6 □ Other (Specify) 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Yes 2 No investigation 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State)

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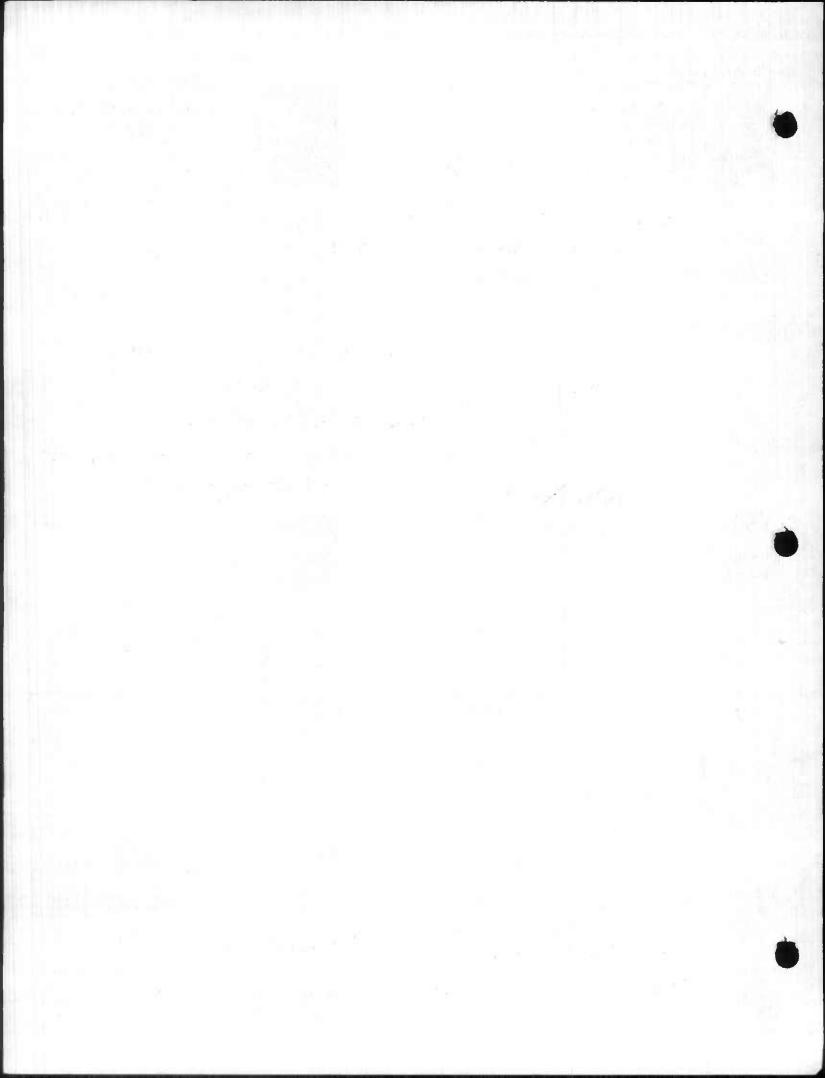
1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete and pleca, end due to the ceuse(s) end manner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) end manner steted. 29e. Certifier 29b. Signeture end Ittle of certifier 29c. License number 29d. Dete signed (Month, Day, Year)

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Churchhill Rd., Chestertown, Md. 6602 21602 32. Registrer's Signature

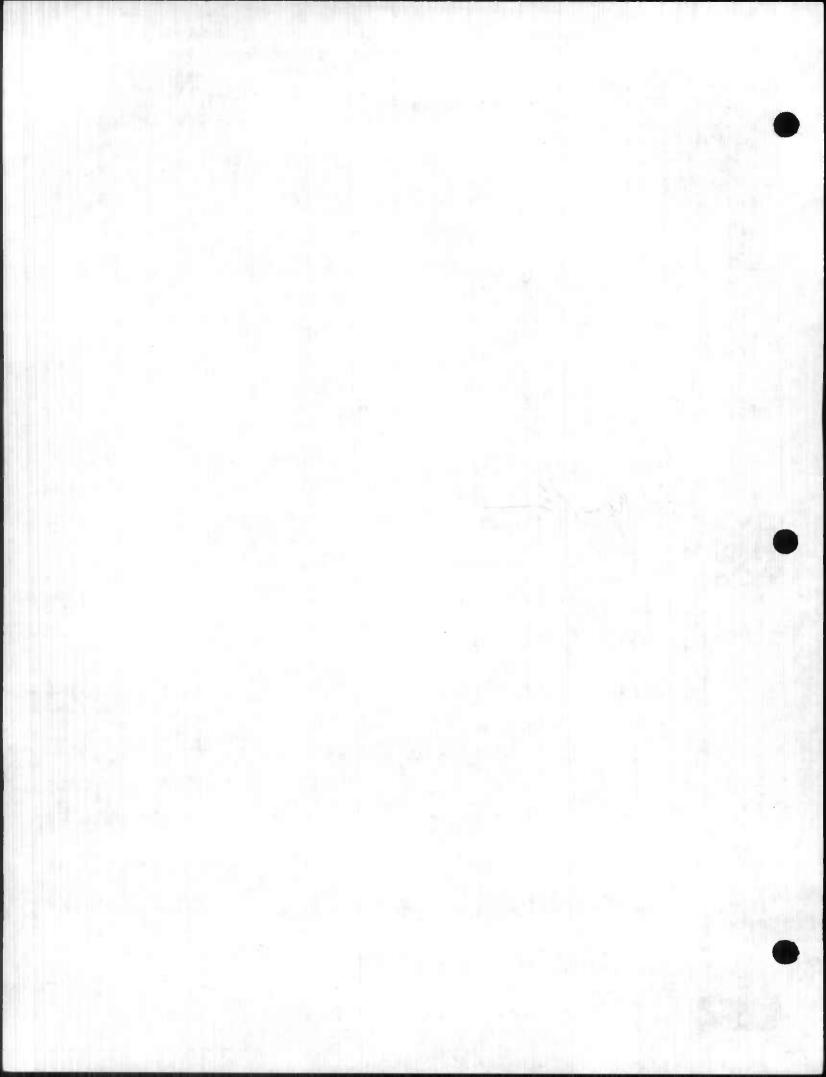
State Registrar



Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	Certificate of	f Death	Re	g. No.								
	1. Decedent's Nama (First, Middla, Last)		2. Data of Death Month		3. Tima of Death							
ician dical	Gail Bartholomew Osgood		October									
ner	4a Facility Nama (If not institution, give street and number)	4b. City, Town, or Lo	cation of Death	4c. County of De								
	Frederick Memorial Hospital 5. Social Sacurity Number 6. Sax 10 M 20 F 7. Aga (In yrs. last birthday) 46 Yrs. Months Days		ck 8. Data of Birth (Month, Day) Feb 25,	0.5	rederick 9. Birthplaca (Stata or Foreig Country) Maryland							
	Usual Rasidanca of Decedant 10a. Stata 10b. County 10c. City, Town or Location				40d toolds Oils I be							
	Maryland Frederick Frederick				10d. Insida City Lim 1 □ Yas 2 □							
Director												
	10e. Street and Number 10f. Zip Coda		10	Og. Citizan of What								
aral	234 East Second Street 11 Marital Status 12. Was Decedant Evar in U.S. 13. Was Decedent of	21701	ait. Vac as No		S.A.							
by Funeral	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced 12. Was Decedant Evar in U,S. 11. Yes, Give Yes, Give Yaar or Datas: 13. Was Decedent of If Yas, specify Cu If Yas, Specify Cu I Yas 2 No I Yas 2 No I Yas 2 No	Hispanic Origin? (Spe uban, Maxicen, Puarto o Specify:	Rican, atc.)	Black, W Specify:								
100	15. Decedent's Education 16a. Decedent's Usual Occur	upation	200	16b. Kind of Busina	ss/Industry							
Completed	(Specify only highest grade completed) (Give kind of work done life. DO NOT use retired to the life. DO NOT use retired life. DO NOT use retired to the life.		ng									
100	Pre-School Te	eacher		Early E	ducation							
ne c	17. Father's Name (First, Middla, Last)	18. Mothar's Nama										
10	Mel Bartholomew	Virgini	a a	Ann	Snyder							
	19a. Informent's Neme/Ralationship (Type, Print) Stephen Bartholomew/Brother 19b. Meiling Addrass (Strae 234 East Se											
	11 I Hurial 2 IVI Tamation 31 I Hamoval from Stata	1 ☐ Burial 2 ☑ Gramation 3 ☐ Ramoval from Stata cematary, cramatory or other place)										
detached for use as the bunal-transit Dhysician/Medical Examiner	Immediata Causa (Final disaasa or condition rasulting in death) Dua to (or as a consequence of):	hosis			14B							
sici	Part II. Other eignificant conditions contributing to death but not rasulting in the underlying ceuse g	givan in Pert I.	23b. Did to	ute to the cause of dea								
Phy	Pne	1 🗆 Ye	2000 3E	Probably 4 Unkn								
Completed by Physician/	Polymonia		24a. Was an		b. Were autopsy findin evailable prior to complation of causa of death?							
MO			1 □ Ya	is Deno	1 □ Yas 2 □ No							
BeC	25. Was casa refarred to medical	26. Placa of Death	n (Check only on	a)								
ToB	axeminar ² 1	Othar: 4 Nursing Ho	ma 5 Rasida	ince 6 Othar (S	(pecity)							
Certification: 1	27. Mannar of Death Description 28a. Data of injury (Month, Day Year) 28b. Tima of Injury W 11	ijury at Vork? Yas 2 No	28d. Dascribe ho	ow injury occurred								
tific	3 ☐ Suicida 4 ☐ Homicide 6 ☐ Could not be detarmined 28a. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)	Ce .	28f. Location (St. City or Town		Rural Routa Number,							
Ö	29a. Certifier (Check only (Check only 2) Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, deta and place, end due to the causa(s) end mennar as stated.											
edicai Cei		y opinion, daath occurr		29d. Data signed (Month, Day, Year)								
Medicai Cei	(Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my and manner stelled. 29b. Signature and title of cartifier 29c. Licen	insa numbar		200	onth, Day, Year)							
edicai	(Check only 2 Medical Examiner: On the basis of examination and/or invastigation, in my one)	insa numbar		200								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time I Death Month Day Sister Gabriel O'Byrne October 30, 2000 11:20 P.M. 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth St. Vincent Care Center Emmitsburg Frederick If Under 1 Year If Under 24 Hrs. Hours Min. 7. Aga (in yrs. last birthdey) 5. Sociel Security Number 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) Months Days 1□M 2□F Yrs 579-66-6798 87 Dec. 25, 1912 New York Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 X Yas 2 □ No Frederick Emmitsburg 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code 335 South Seton Avenue 21727 U.S.A. 12. Was Decedant Evar In U,S. Armed Forcas? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - Amarican Indian, Black, Whita, atc. ☐ Yes 2 No I Yas, Giva 1 Nevar Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: 3 Widowed 4 Divorced Yaer or Detas: White 18a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Religious Community Elamantary/Secondery (0-12) College (1-4or 5+) Secondary 10 Nursing Daughters of Charity 17. Father's Neme (First, Middla, Last) 18. Mother's Neme (First, Middle, Maidan Sumeme) Ambrose O'Byrne Elizabeth Clinton 19e. Informent's Neme/Ralationship (Type, Print) 19b. Melling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister Camilla Harant 333 South Seton Ave., Emmitsburg, MD 21727
of Disposition (Name of Data 20c. Location - City or Town, State 20b. Plece of Disposition (Name of cemetery, cremetery or other piece) 20e. Mathod of Disposition 1 X Buriel 2 ☐ Cramation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) JOSEPH S P. H. 11/2/2000 EMMITSBURG, MD. 21727 21. Signature of Funerel Sarvice Licenses/) 22. Nama and Addrass of Facility SKILES FUNERAL HOME ales 210 W. MAIN ST., EMMITSBURG, MD. 21727 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, or heart feitura. List only one cause on each line. Immediate Cause (Finel disease or condition resulting In death) Due to (or as a consequence of): Sequentielly list conditions, if any, leading to immediate causa. Enter Underlying Ceuse (Diseese or injury that initiated events rasulting in daath) Last Due to (or es a consequence of) Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown 24b. Were autopsy findinge available prior to completion of causa of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 28. Place of Deeth (Check only ona) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA 28d. Describe how Injury occurred 28b. Tima of

Physician /Medical **Examiner**

permit. Peges Department of Important: If It any Injury or o

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show

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Completed

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Peges 1 end 2 should be filed within 72 hours after deeth with the Maryland nent of Heetith and Mentel Hygiene. or items 23s or 28s-f show nt: If Item 27 is marked other than "natural", or items 23s or 28s-f show

Baltimore, Maryland 21215-0020

7 is marked other than "natural", or items 23s or traumatic event, the Medical Examiner must be

Examiner physician and the buriel-transit Physician/Medical 88 980 signed by the a þ Completed page 2 s certificate has Be 2

requires that the death certificate be executed After this funeral death.

Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: after death Director: 24 hours

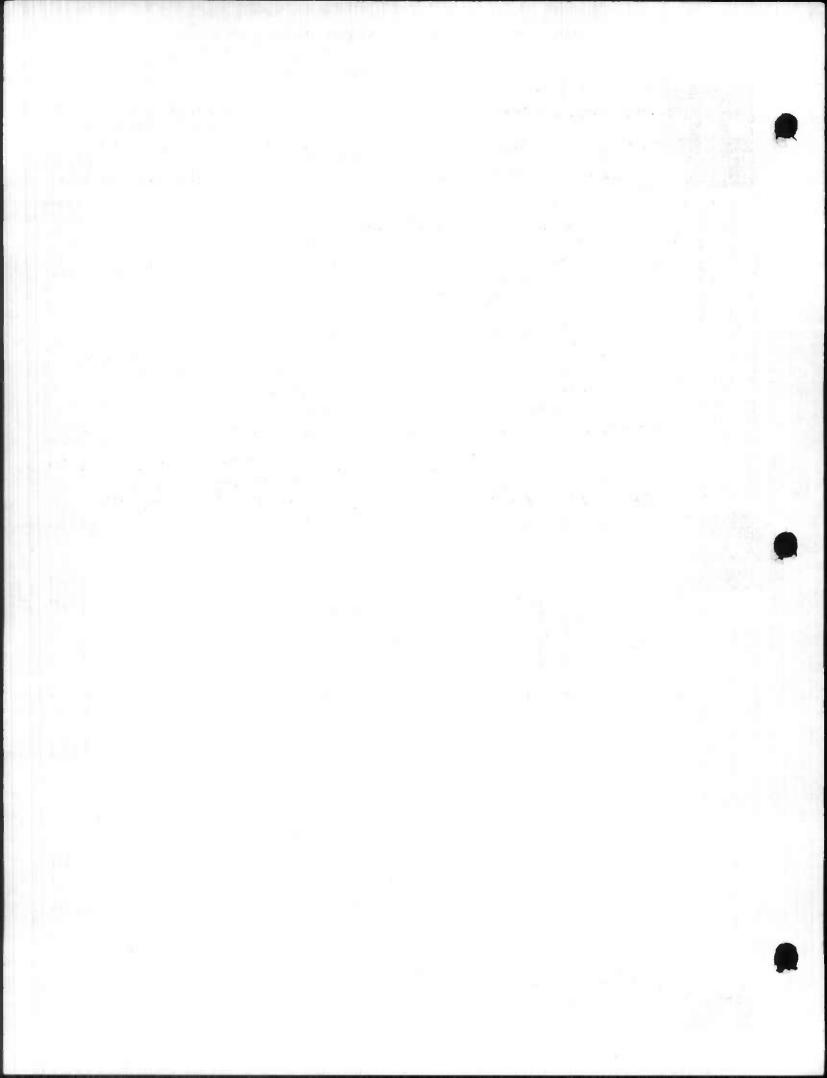
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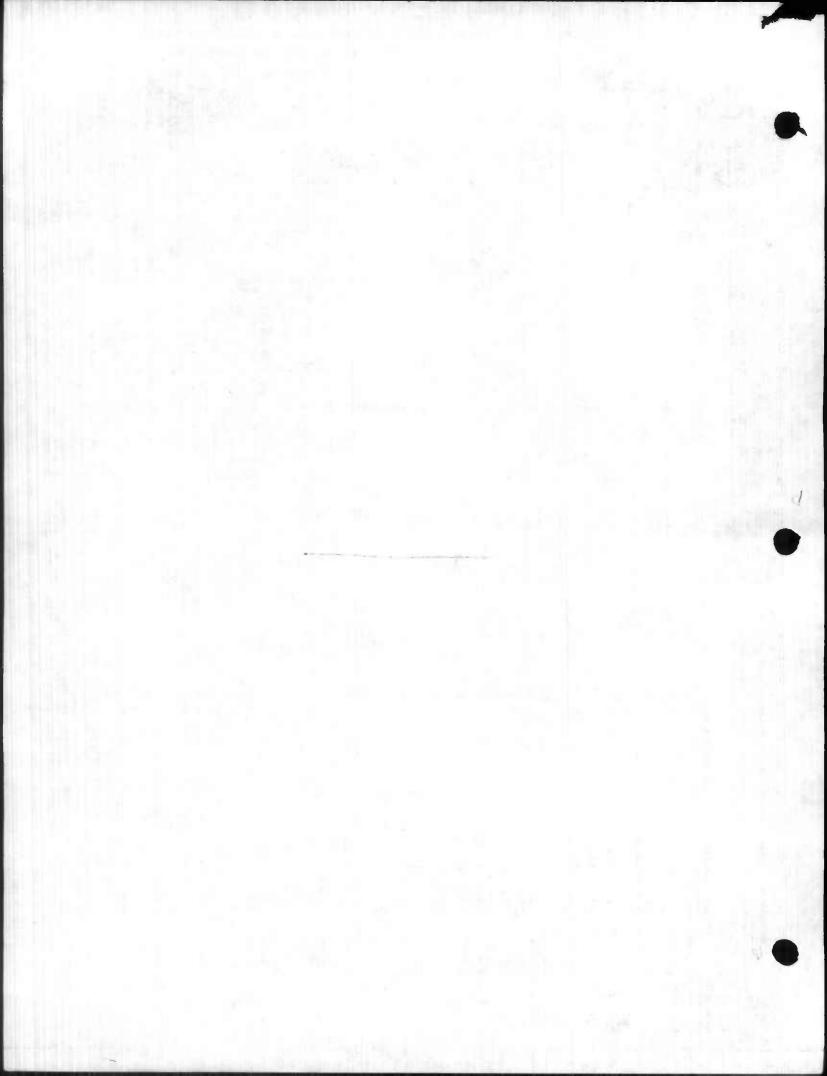
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25. Was case referred to medical exeminer? 1 Yes 2 No 27. Menner of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 1 Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicida 28e. Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29e. Certifier 1 🛱 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and plece, end due to the cause(s) and menner es stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and menner steted. 29c. Licansa number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier OCTOBER 31, of deeth (Item 23a) (Type Print) Nema end address of person who complated causa of 52 STREE BONITATI KREMPEL. 32. Registrar's Signeture 2000



#23a,	11/2/2000,BMW,N			Cei	rtifica	te of	Death			Reg. No.				
Physician	Decedent's Neme (First, Min	ddle, Last)						1	Dete of De Month	ath Dey	Year	3. Time of Death		
/Medical		Novikovs					41 On T		October 26, 2000			10:15 pm		
Examiner	4e Facility Name (If not institu							or Location of Death 4c. County of Deeth						
	Washington A 5. Social Security Number	dventist 6. Sex	7. Age (In yrs.		If Unde	r 1 Year	akoma If Under 24				gome	ry lace (Stete or Foreig		
ineral rector	576-46-4628	1⊠ M 2□		Yrs.	Months	Deys	Hours	Min.	8. Dete of Bird (Month, De April		Russ	try)		
CCIO	Usuel Residence of Decedent	I. As et al.	19						Whill	9,1921	Nuss	ıa		
Now III	10a. Stete 10b. Cou	nty	10c. Ci	ty, Town or Lo	cation					0d. Inside City Limits				
oto	Maryland Mont	gomery		Silver	Silver Spring							1 ☐ Yes 2 ☑ No		
or 28s-f s be nout so Director	10e. Street and Number				10f. Zi	Code				10g. Citizen of V	Vhal Coun	try?		
	1624 Oaklawn C	ourt				2	20903			USA		The same		
doer must Funeral	11. Meritel Sletus	Ame	12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Original Interpolation (Interpolation of the Interpolation of			lispenic Origi en, Mexicen,	n? (Spe Puerto l	cify Yes or No Ricen, etc.)	- 14. Rec Bled	e - Americ k, White,				
	1 Never Merried 2⊠ N	If Ye	res 2⊠ No s, Give		1 🗆 Yes		Specify:			Specify				
d b	3 Widowed 4 Divor		or Detes:	10.0	4 - 41 - 8 1 -	-10	-at			40h Kind of D	Whi			
t, the Medical Completed	(Specify only hig	lent's Educetion hest grade comple	de completed) (Give kind of work done during life. DO NOT use retired)				ation during most o	ol workir	19	16b. Kind of Bu	ISIN OSS/INC	ustry		
di di	Elementery/Secondary (0-1)	Colle 5+	ge (1-4or 5+)	Archi		90 1011101	-/			County	Government			
marked other than "naturel", imetic event, the Medical Ex- To Be Completed by	17. Felher's Neme (First, Midd			ALCIII	Lect		18. Mother	s Name	(First, Middle,	Meiden Sumer		rimeric		
atic even	Nilealaia Navi	1					M414.	n Do	rlbachs					
	Nikolajs Novi)	19b. Mellin	ng Addres	s (Street					Stete, Zip	Code)		
Important: If New 27 is marked other than any Injury or other traumatic event, the Monce. To Be Comp	Ligita Noviko	Ve	(wife)		Helling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Oaklawn Court Silver Spring, Maryland 20									
etto etto	20a. Method of Disposition 20b. Pleca of Disposition (Name of Dete 20c. Location - Cit											- City or Town, Stete		
۵ بر ۲ بر	1 Los Buriat 2 Li Cremetion 3 Li Hemovel from Stete									10/30/00 Washington, D.C.				
in in	4 Donetion 5 Other (Specify) Rock Creek Cemetery 10/30/00 Washington, D.C. 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Francis J. Collins Funeral Home, Inc.													
eny ir	1 John	5 1	ns F	uneral	Home, I	nc.								
	23a. Pert1. Enter the distance shock, or hear failule. 1	or complications t	hat caused the dee	Ih. Do not ente	O Uni	vers	sity B	Lvd.	w. Si	ver Spr	ing.l	MD 20901 Approximate		
sician edical miner	Immediate Cause (Final disease or condition resulting in death)	8	7,24	or as a conseq	100		Q-	H			1			
bunel-transit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying	S b.	Due to (or as a conseq	juence of)	:					1			
E P	Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or es a consequenca of):											
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sge 2									10	res 2 No	1.	Yes 24 No		
certificate nes rector, page 2 Be Comp	25. Was case referred to med	cal					26 Place	of Death	(Check only o			2.00		
	examiner?	Hospitel.	Inpatient 2	TER/Outpetien	t 3[] D	OA Oth	Mar.			dence 6 □Oth	er (Specif	v)		
After th funeral fon:	27 Menner of Death Neturel 5 □ Per	ding 28a. [Date of Injury Month, Dey Year)	28b. Time of Injury		28c. Injui Wo		2		how injury occur				
To the Funerel Director: After the completely filled in by the funeral Medical Certification:	3 ☐ Suicide 6 ☐ Cou	ld not be mined 28e.						2	28f. Location (. City or To	Street end Numb vn, Stete)	er or Rure	I Route Number,		
pletely fille		al Examiner: On t	the best of my know the basts of examine manner steted.											
To th	29b. Staneture and title of cert	To feith	140		29	c. Licens	e number			29d. Dete signe	d (Month,	Day, Year)		
	1 cm	1. 101	Allh.	MD		1.1	671			10)	271	00		
	30. Name and address of pers James L. Cock		cause of deeth (Itel			1 Av		ot.	CD, Tal	koma Par	k, MI	20912		

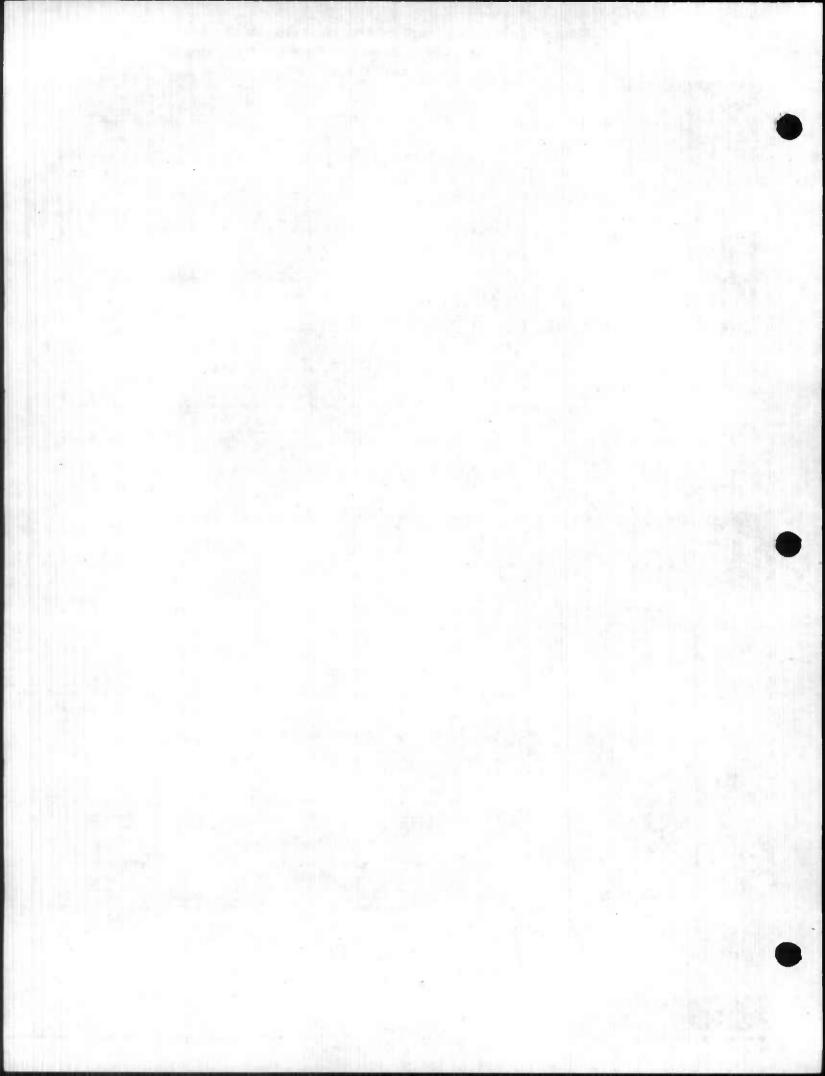


State of Maryland / Department of Health and Mental Hygiene 0 0 36221

	Certificate of Death	ל	Reg. No.				
Editor:	Decedent's Name (First, Middle, Last)	2. Dete of De Month	Day Year	3. Time of Death			
Physician /Medical	Peter J. Piecuch	Octob		5:15 AM			
Examiner		fown, or Location of Deat					
	9910 Ashburton Lane Beth		Montgomery				
Funeral Director	113-24-7797 18 M 2 F 68 Yrs. Months Deys Hours	Min. 8. Dete of Bir (Month, Da Jan. 3]	ly, Year) Co	thplace (State or Foreign puntry) 7 York			
p	Usual Residence of Decedent 10a. Stele 10b. County 10c. City, Town or Location			10d. Inaide City Limits			
Maryla f sho led at				1 ☐ Yes 2 🖺 No			
or 28e-f s be notified Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	ountry?			
			United Sta	ates			
her death or them 23 siner must	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic C	Origin? (Specify Yes or No	14. Rece - Ame Bleck, Whit				
036 by	1		Specify:	nite			
5-0-57 72 72 72 72 72 72 72 72 72 72 72 72 72	15. Decedent's Education 16a. Decedent's Usual Occupetion (Specify only highest grade completed) (Give kind of work done during mo	ost of working	16b. Kind of Business/	findustry			
21215-0 ad within 72 ho typiens. or than "natur t, the Medical Completed	Elementery/Secondery (0-12) College (1-4or 5+) 5+ Editor		Technical J	Journal			
d 2		her's Neme (First, Middle		Journal			
land lid be il de several H le several H le several H le several l		Sophia Grybo					
ary and work with the work of	19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Addresa (Street and Num.			Zip Code)			
	Kathleen J. Piecuch/Wife 9910 Ashburton Lan	ne, Bethesda	, Maryland	20817			
Saltimore, emit. Pages 1 at appartment of Hea montant: If Hear in y injury or other not.	20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donetion 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemeter	Nov. 3,	Nov. 3, 2000 Silver Spring, Ma				
Balti mit. 7 partm ringe	21. Signelure of Funerel Service Licensee Robert A. Pump						
m sages	M00198 7557 Wisconsin Bethesda, Mary	Avenue	Ch	nase, Inc.			
	23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such a shock, or heart/ailure. List only one cause on each line.	as cardiec or respiretory e	rrest,	Approximate Intervel Between			
Physician				Onset and Deeth			
/Medical Examiner	Immediate Cause (Fine) disease or condition resulting in deeth) a.			tou winn			
9	Due to (orals a consequence of):						
executed and self-transit	Sequentielly list conditions. Due to (or es e consequence of):						
'60, be executed sician and buriel-transit sal Examin	Sequentielly list conditiona, if any, leeding to immediate cause. Enter Undertying Cause (Disease or injury						
68760, ficate be en physician as the burial edical E	Cause (Disease or injury thef initieted events resulting in death) Last Due to (or es a consequence of):						
2 6 5							
Box eath ce attendir for use	d						
.O. the de y the a sched f	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Per			to the cause of death?			
igned by the abote detached by Physic		10	Yes 2 No 3 P	robably ADUnknown			
Il Records, P.O. Box The law requires that the death ce rate has been signed by the attendit page 2 should be detached for use Completed by Physician/I		24a. Wes		Were eutopsy findings			
w require		perfe	ormed?	available prior to completion of cause of death?			
The law ate has the page 2 s		10	Yes No	1 ☐ Yes 2X No			
Vital Function: The certificate irector, pag	25. Was case referred to medical 26. Pia.	ce of Deeth (Check only					
	examiner? 1 Yes 28 No Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 In	Nursing Home 5 Resi	idence 8 Other (Spe	ecify)			
on o aling Ph h. After thi funeral	27. Mepner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of linjury at Work?		how injury occurred				
Vision Attending or death. ector: Afte by the fune	2 Accident investigation M 1 Yes 2L			10-10-1-1			
Division of or Attending Physical death. Director: After this in by the funeral deriffication: Terrification: Terrification: Terrification: Terrification: Terrification:	3☐ Suicide 4☐ Homicide 4☐ Homicide 4☐ Homicide 4☐ Homicide 28e. Plece of Injury - At home, ferm, streel, factory, office building, etc. (Specify)	City or To	(Street and Number or R wn, State)	urai Houle Number,			
Division C To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification:	29a. Certifier 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete	and place, and due to the	ceuse(s) end menner e	s stated.			
P Hos	(Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, de and manner steted.						
To the comp comp	29b. Signeture and fittle of counties 29c. License number	no	29d. Dale signed (Mon.	th, Day, Year)			
10+1	1 MULC M (7536	086	300 JON 3	1,2000			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	100	no mo	2000			
	Kerrall 1/10/00 18/1/ MUCH	11/10 N.C	MATHIA	487			
State Registrar	31. Dete filed (Month, Day, Year) 32. Registrer's Signeture						

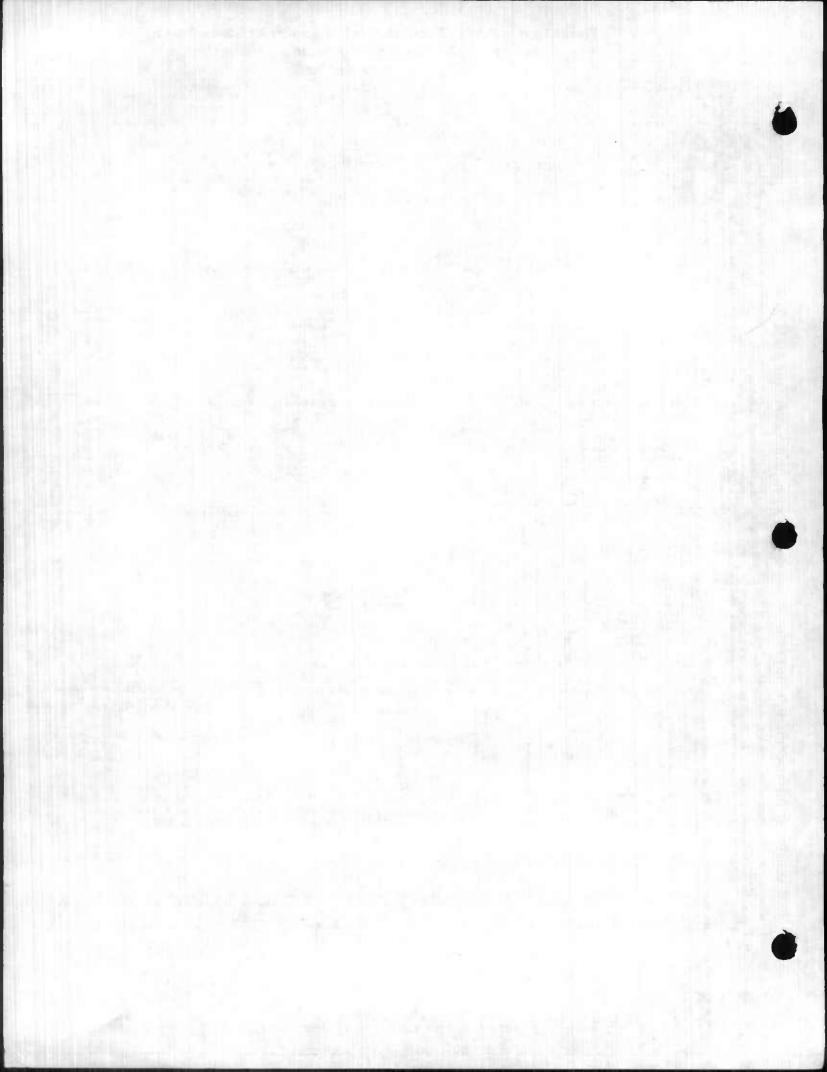
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ORIGINAL



State of Maryland / Department of Health and Mental Hygiene

s. last birthday) If Under 1 Yee Months Days	4b. City, Town, or Local Silver Spri					
	Silver Spri	ion of Death 4c. County				
		ma Manta				
O Was Michiella Days	Hours Min.	Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)			
8 Yrs.		Sept. 8, 1922	New York			
city, Town or Location			10d. Inside City Limits			
		1 N Yes 2 □				
		10g. Citizen of V	Whet Country?			
	Hispanic Origin? (Specif		States			
rld			ck, Whita, etc.			
r 11			Black			
(Give kind of work done	e during most of working		usiness/industry			
			ce/U.S. Gov't			
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Placa of Disposition (Name of	6	Date 20c. Location	- City or Town, State			
	INO		la, Maryland			
22. Name end Add	ress of Fecility Robe	rt A. Pumphre	ey Funeral Home			
0803 Bethesda,	Maryland	20814-3501	wisconsin ave.			
eth. Do not enter the mode of dy	lng, such as cardiac or re	espiretory arrest,	Approximate Interval Between Onset and Death			
			Oriset and Death			
The state of the s						
tact infection			1			
sulting in the underlying cause g	given in Part I.	23b. Did tobacco use co	ontributs to the cause of death?			
Colectomy & I1	eostomy	1 ☐ Yes 2 ☐ No	3 Probably 4 ™ Unknown			
		24a. Wes an autopsy	24b. Were autopsy findings			
		performed?	available prior to completion of cause of death?			
		1 ☐ Yes 2 No	1 ☐ Yes Ž☐ No			
		Check only one)				
JENOUIPALIENT SLI DON	4 Housing Home					
		s. Describe now injury occur	1160			
home, tarm, street, factory, office	a 281	Location (Street and Numi	ber or Rural Route Number,			
owledge, death occurred at the attion and/or investigation, in my	time, dete end placa, and opinion, death occurred	due to the cause(s) and mat the time, date and place,	anner as stated. , and due to the cause(s)			
29c. Lice	nse number	29d. Date signe	ed (Month, Day, Year)			
29c. Lices D522						
			31, 2000			
D522	261	October				
	10f. Zip Code 08 20008 U.S. 13. Was Decedent of If Yes, specify Curld 1 Sepecify Curld 1	ashington, D.C. 10f. Zip Code 08 2008 U.S. 13. Was Decedent of Hispanic Origin? (Specification of the control	ashington, D.C. 10f. Zip Code 10g. Citizen of			



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** EDNA October 27, 2000 0845 AM LOIS PILCH /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not Institution, give street and number) 4c. County of Death Examiner Montgomery Bethesda Suburban Hospital H Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Yeer 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1□M 2⊠F Yrs. 1913 Ohio 86 Dec. 16, Director 216-38-5157 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20817 U.S.A. 8726 Ewing Drive Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2X No Specify: Specify: White þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Medical Registered Nurse 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Rev. Edward Lewis Miller Galbraith Anna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) Bethesda, MD 20817 (Daughter) 8726 Ewing Drive Tamara G. Pilch 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/30 Maurertown, Virginia Maurertown Cemetery 22. Name and Address of Facility
JOSEPH GAWLER'S SONS, INC. 21. Signature of Funeral Service Licansee DC 20016 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 5130 WIsconsin Ave., NW Washington, Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Cardio-Respiratory Insufficiency 2 months Due to (or as a consequenca of): Physician/Medical Examiner vears Arteriosclerotic Heart Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in death) Last Due to (or as a consequence of): Due to (or es a consequence of) Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 N Probably 4 T Unknown Chronic Obstructive Pulmonary Disease p 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? Spinal Stenosis

Physician /Medical Examiner

The law requires that the death certificate be exec

signed by

After this certificate has

Director:

within 24 hours a To the Funeral C

10

completaly

Hospital or Attending

To the

Solch, Lois

page 2 should

the funeral director,

Certification: To

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29a. Certifier

景 must be notifi

flams 23a or

6

72 hours after

Illed within Hygiene.

Jemit. Pages 1 and 2 should be I Department of Health and Mental 9 Important. If them 27 is marked of

8

21215-0020

Maryland

altimore,

use as the burial-tran pue

25. Was case referred to medical examiner? Hospital: 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

1☐ Yes 2X No 27. Manner of Death 1 X Natural

5 Pending investigation 2 Accident 3 ☐ Sulcide 6 Could not be determined 4 Homicide

28a. Date of Injury (Month, Day Year) 28b. Time of

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Yes 2 No

29b. Signature and title of certifie

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

26. Place of Death (Check only one)

October 28, 2000

1∏Yes 2□No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

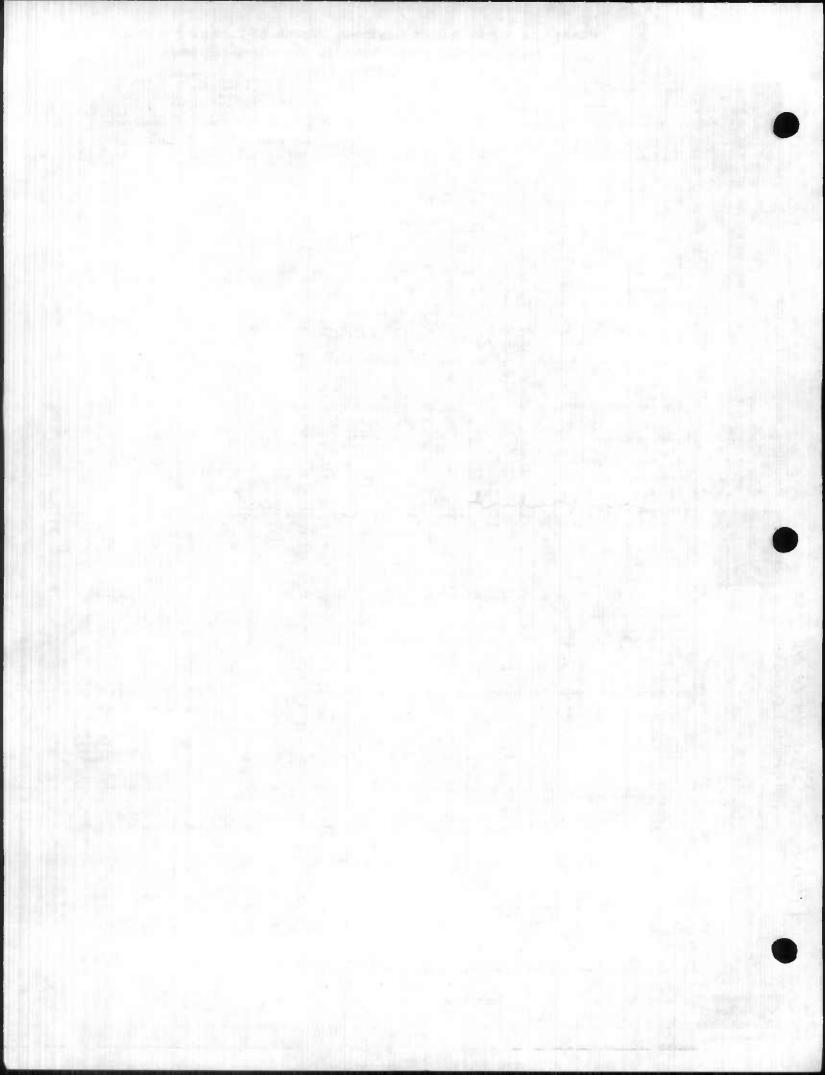
Kensington, MD 20895 10400 Connecticut Ave., Eugene P. Libre, M.D.

State Registrar

31. Date filed (Month, Day, Year) OCT 31

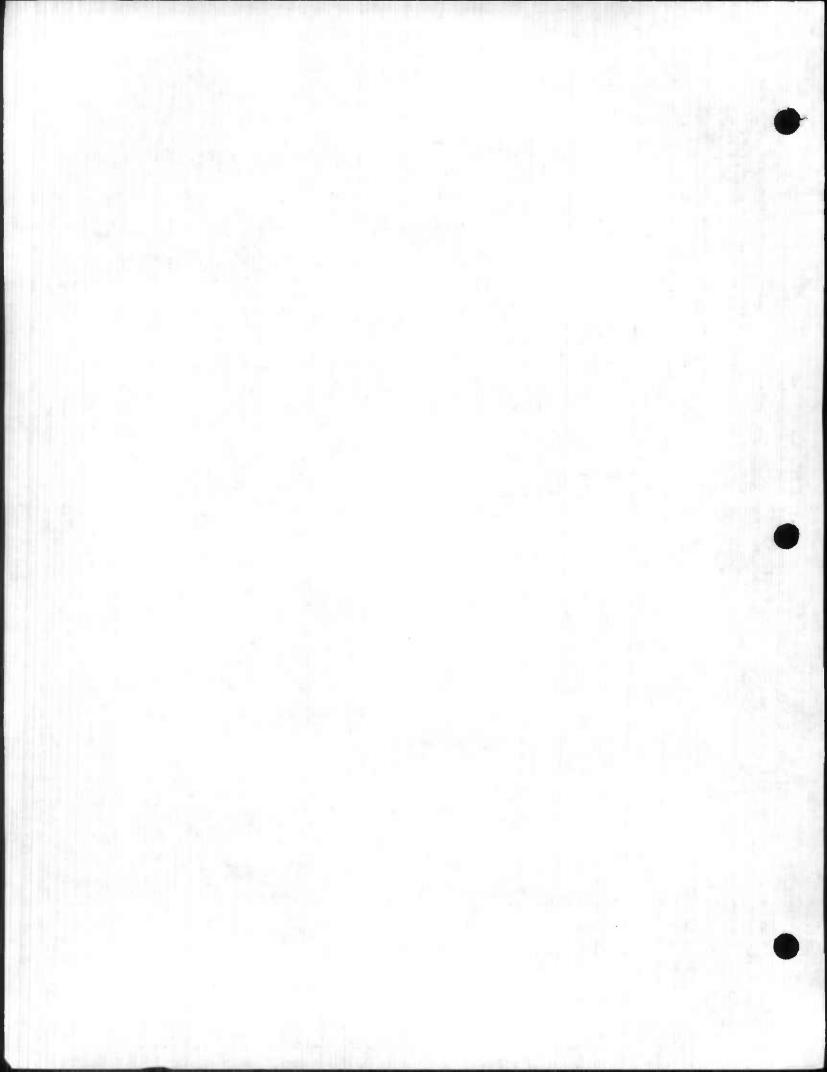


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State of Maryland / Department of Health and Mental Hygiene 0 0 36227

			C	ertifica	te of	Death			Reg. No.			
	1. Decedent'a Name (First, Middle, Las	t)	-					2. Date of De	ath		3. Time of Deat	
ysician	Ana M. Porti		Octobe	r 25, 2	2000	8:00 pm						
Medical	4a Facility Name (If not institution, give	street and number)				4b. City, Tov	vn, or Lo	cation of Deat		y of Death		
kaminer	10920 Connecticut	The state of the s	504				netor				~w	
	5. Social Security Number 6. Se		n yrs. last birthde	(V) If Und	er 1 Year						olace (State or Fore	
neral ector		□M 201F	77 Yrs.	Months	Deys	Hours	Min.	July 2	th Year) 25, 1923	EIS	lvador	
ctor	Usual Residence of Decedent											
or state	10a. Stete 10b. County	10	c. City, Town or	Location					10d. Inside			
for tor	Maryland Montgome:	rv	Kensing	ton						1 □ Yes Ž		
be notified Directo	10e. Street and Number				ip Code				ntry?			
	10920 Connecticut	Avanua Ant	504	20	895				El Salv	rador		
era a	11. Merital Stetus	12. Was Decedent Eve				Hispanic Orig	in? (Spe	city Yes or No		ce - Americ	can Indien,	
iner must Funeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🖾 No		7.7			Puerto F	city Yes or No Rican, etc.)	Bia	ck, White,	etc.	
by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Detes:		1 Yes	2 No	Specify: E1Sa1	lwade	rian	Specia	y: Whit		
	15. Decedent's Ed	1710,2000 1010	16a De	cedent's Us	ual Occut	nation			16b. Kind of B			
Completed	(Specify only highest grad	de completed)	(G.	ive kind of w	ork done	during most	of workir	ng			,	
E E	Elementary/Secondary (0-12)	College (1-4or 5+)		4.4					Orm Ho			
	17. Father's Name (First, Middle, Last)		поше	emaker		18. Mother	r's Name	(First, Middle	Own Ho Maiden Sumai			
Be												
2	Rafael Zelaya	D-1-1)	101-14	a Minera Andréan	(04	-		ortillo		Ctoto 7i	Codel	
	19e. Informent's Name/Relationship (7								er, City or Town			
2	Jose Roberto Port					d Road	1, S:		pring,			
5	1X Burial 2 Cremation 3 DRemoval from State cemetery, crematory or other place)											
	4 □ Donation 5 □ Other (Specify)	Cemetery $10/28/00$ Silver Spring, M					_				
8	21. Signature of Funeral Service Licent	500)		22. Name	and Addre	ess of Facility	line	Funor	1 Home,	Tno		
5 8	John 8. (2	ahen									ng, MD 20	
	23a. Pert 1. Enter the diseese, or comp	plications that caused the	e deeth. Do not	enter the mo	ode of dvi	ng, such es	cardiac o	r respiratory a	rrest.	Sprii	Approximate	
.,	shock, or heaft feilure. List only of	one cause on each line.									Intervel Between Onset and Deat	
ian ical	Immediate Cause (Finel											
ner	disease or condition resulting in death)	a. Metastic	Small (Cell (Cance	r					1 year	
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i a		b						4		i		
Examiner	Sequentially list conditions,	Due	e to (or es a con	sequence of):							
m m	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C.										
edicai	that initieted events resulting in death) Last	use (Disease or injury c. Due to (or as a consequenca of): Uting in death) Last										
for use as the burial-transit clan/Medical Examir												
an Z		d										
90	Part II. Other significant conditions co	contributing to death but not resulting in the underlying cause given in Pert I.						23b. Did tobacco use contribute to the cause				
detached for us	75 TO THE 12 HO							10	bably 4X Unk			
d by P							1					
2									an autopsy ormed?		ere autopsy finde vailable prior to	
Completed								peri	Ollinea I	CC	ompletion of caus	
Сощр								40	Yes 2 No		Yes 2X No	
5 0										1	LI Yes ZALI NO	
8	25. Was case referred to medical examiner?	Hospital:			Ot	hae		(Check only				
TO 1	TESTES ZUNO	1 L Inpatient	2 ER/Outpa		JUA				how injury occu		fy)	
completely filled in by the funeral director, Medical Certification: To Be (27. Manner of Death 1 ☑ Naturel 5 ☐ Pending	28a. Date of Injury (Month, Day Yo	ear) 28b. Time Injur	У	28c. Inju			LUG. DUSCHOO	now injury occu	1100		
Certification:	2 Accident investigation 3 Suicide 6 Could not be		4-14-31	М] Yes 2 🗆 !		004.1	(0)	h	of Power Maria	
=	4 Homicide determined	28e. Placa of Injury building, etc. (3	 At home, farm, Specify) 	street, facto	ory, offica		1		(Street end Nurr wn, State)	per or Ruf	al Route Number,	
Ö										1 3		
edical		ysician: To the best of m										
P	one)	iner: On the basis of ex and manner stated	aminetion end/oi 1.	rinvestigalic	on, in my	opinion, deat	tn occurr	ed at the time	, dete end place	, and due i	o trie cause(s)	
2	29b. Signature and mis-of certifier	- 1		2	9c. Licen	se number			29d. Dete sign	ed (Month,	Day, Year)	
	D 33224								October	27	2000	
	20 Name and address of names it	completed array of death	h (Hom Ode) (To		, ,,,,,				occoper	. 21,	2000	
	30. Name and address of person who o				20 5			m 000	250			
	· ·	0 W. Edmons		ve #30) KC	CKV11.	re, l	208 עני	352			
State	31. Date filed (Month, Day, Year)	32 Registrar's	Signature 4	do	ne V							
iletrar -	1111 0117 (11	UU /h/	fort.	dell's	1000							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month PAULINE PORTNER October 27,2000 11:20pm 4a. Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 34 Spring Street Gaithersburg Montgomery If Under 24 Hrs. 8. Deta of Birth (Month, Day, Year) 5. Sociel Sacurity Number If Undar 1 Yeer 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) Days 1 M XXF Months Yrs. 525-84-6564 63 03/03/1937 New Mexico Usuel Rasidanca of Dacadant 10c. City. Town or Location 10b. County 10d. Insida City Limits Gaithersburg Montgomery 1 Yas 20 No 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 34 Spring Street 20877 United States 12. Wes Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Give Was Dacedent of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Mexican, Puarto Rican, atc.) Race - Amarican Indian, Black, Whita, atc. 1 Navar Marriad 2 Married 1 ☐ Yas 2X No Specify: Specify: 3 ☐ Widowad 4 ☑ Divorced White 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use ratired) 15. Decadant's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) Care Giver Child Care 17. Fethar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Malden Sumama) Edward Bustamante Mary Padilla 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda) Christine Tench, daughter 34 Spring Street Gaithersburg, MD 20877 20b. Placa of Disposition (Name of cematary, cramatory or other placa) 20e. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☑ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) NorthernVA Crematory 10/31/00 Arlington, VA 21. Signeture of Fund 22. Nama and Addrass of Fecility Old Town Funeral Choices 1205 Belle Haven Rd., Alex., VA 22307 e, of complications that causad tha death. Do not entar tha mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 234 Prit1. Enter the disees shock, or heart failura. Approximata Intervel Batwaan Onset and Death Ha of Metastatue Breat cause Immediata Cause (Final diseesa or condition resulting in daath) Dua to (of as e consaquanca of) Saquentially list conditions, if any, leading to immediata causa. Entar Underlying Causa (Diseasa or Injury that initiated avants resulting in daath) Last Dua to (or as a consequence of) Dua to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 □ Probably 4 □ Unknown llek 24b. Wara autopsy findings available prior to 24a. Wes an autopsy performed? completion of cause of death? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarrad to medical axeminar? 28. Piaca of Daath (Check only ona) Othar: 4 Nursing Homa 5 A Residence 6 Other (Specify) 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Daath 28c. Injury at Work? 28b. Tima of 28d. Describe how injury occurred 5 Pending Invastigation 1 ☐ Yas 2 ☐ No 6 Could not be datarminad 28a. Placa of Injury - At home, ferm, straet, fectory, offica building, atc. (Specify) 28f. Location (Straat and Number or Rural Route Number, City or Town, State) 1 Cartifying Phyaician: To the best of my knowledge, death occurred at the time, data end plece, and due to the causa(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signatura end titla of certifiar 29c. License number 29d. Date signed (Month, Day, Year) 3685 10/30/00 aune 4/18

P.O. Box 68760,

Physician

/Medical

Examiner

10a. Stata

MD

Director

Funeral

by

Completed

Be

0

Physician/Medical Examiner

þ

Completed

Be

10

1X Natural

2 Accidant

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicida

Certification:

Medical

Funeral

Director

works !

"natural", or items 23a or 28a-f show

Peges 1 and 2 should be filed within 72 hours effer ment of Health end Mental Hygiene.
ant: If item 27 is marked other than "natural", or ite ury or other traumetic event, tra Modical Examina

permit. Pege Depertment of Important: If any injury or

Physician

/Medical

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After

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Baltimore, Maryland 21215-0020

death with the Maryland

The lew requires that the death certificete be executed Division of Vital Records, Attending Physician: deeth. or Attendi effector: A l Director: A d in by the fi To the Hospital of within 24 hours of To the Funeral D completely filled I

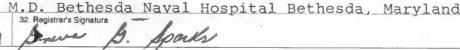
> State Registrar

NOV 02

Maurice Wright,

31. Data filed (Month, Day, Year)

30. Nema and address of person who complated cause of death (Item 23a) (Type, Print)

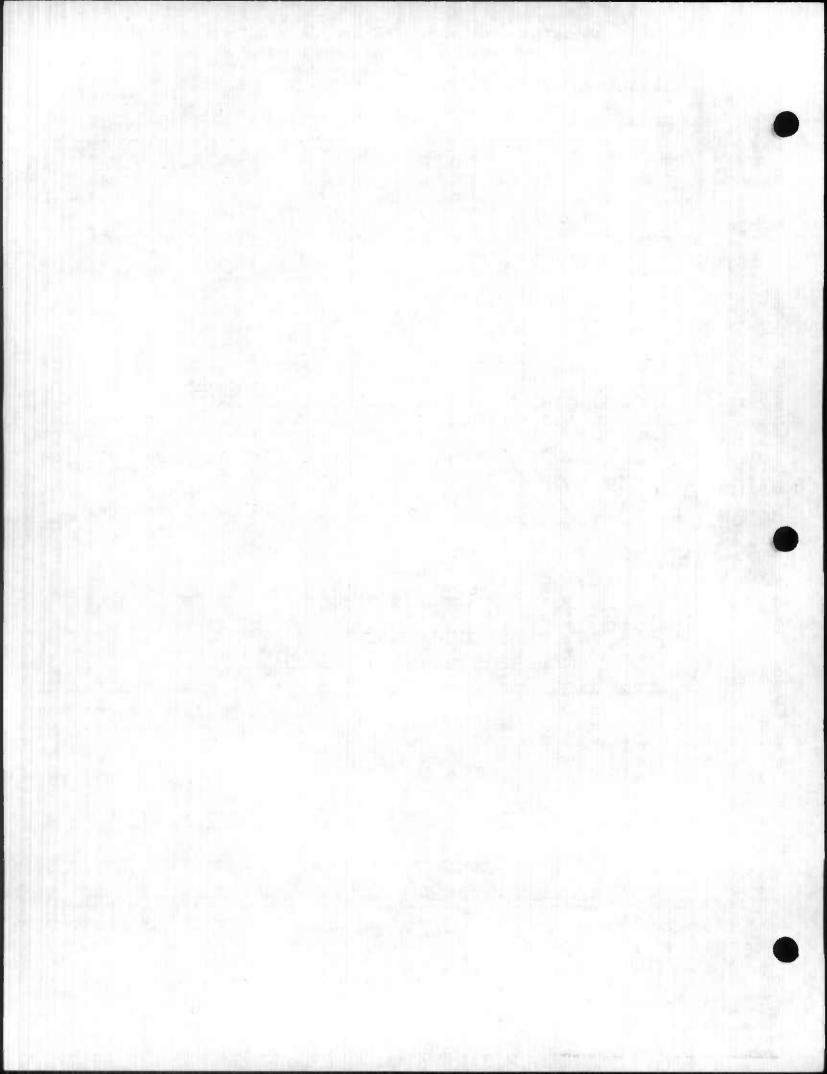


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State of Maryland / Departmen

nt of	Health and	Mental Hygiene	U	U	0	O	6	Ca

			Certificate o	f Death	F	Reg. No.	
	1. Decedant's Name (First, Middla, Last)				2. Data of Dea Month		3. Time of Death
Physician	BEATRICE	PUMPHRE	e.Y		OCT.	30, 200	
/Medical Examiner	4e Facility Name (If not institution, give stre			4b. City, Town, or L	ocation of Death		
LAdillilei	Holy Cross Hos			Cilvor C	nrina	MONTE	COMEDN
	5. Social Security Number 6. Sex	7. Aga (In yrs. last bi	irthday) If Under 1 Yes	Silver S	8. Data of Birtl	MONT	GOMERY Birthplace (State or Foreign
Funeral		1 2 X F 88	Yrs. Months Day		(Month Day	Year)	Birthplece (State or Foreig
Director	216-88-6090	00	1101		Oct. 3	,1912	Maryland
	Usual Rasidence of Decedant 10a. Stata 10b. County	10c City Toy	vn or Location				10d. Insida City Limits
S M P			ilver Spr	na		1 ☐ Yas 2 N	
28a-f sho notified at	MD Montgon	mery 5.	river spr.	Ling			10105 24314
be notified Directo	10e. Street and Number		10f. Zip Code			10g. Citizen of Wha	it Country?
and in	15311 Holly Gro	ove Road		20905		U.S.	Α.
iner must iner must Funeral		Wes Decedant Ever in U.S.	13. Was Dacedent o	f Hispanic Origin? (Sp Jban, Maxican, Puerto	ecify Yas or No-	14. Raca -	Amarican Indian,
1 2	1 Nevar Married 2 Married	Armed Forcas? 1 Yes 22 No	If Yas, specify Cu	iban, Maxican, Puerto	Rican, etc.)	Black, 1	Whita, atc.
by by	3 Widowed 4 □ Divorced	If Yas, Giva Yeer or Detes:	1 ☐ Yes 2 ☐ N	o Specify:		Specify:	Black
	15. Decedant's Educat		Decedent's Heuri Occ	unation		16b. Kind of Busin	nee/Industry
event, the Medical Be Completed	(Specify only highest grade c	ompleted)	Decedant's Usual Occ (Giva kind of work dor life. DO NOT usa reti	a during most of work	ing	TOU. KING OF BUSIN	iessymoustry
a de	Elementary/Secondary (0-12)	Collega (1-4or 5+)					
0 5	8th		House			Hom	ne
86	17. Fathar's Nama (First, Middla, Last)			18. Mothar's Nam	a (First, Middla,	Meiden Sumema)	
0	Harry Holland			Matt	ie Matt	hews	
	19a. Informant's Name/Ralationship (Type	, Print) 19	b. Malling Addrass (Stre	et and Number or Rui	al Routa Numbe	r, City or Town, Ste	ata, Zip Coda) 2090
E	Claudia B. Hall	(Daughter)	15315 Hol:	ly Grove	Rd., 5	Silver S	
ê	20e. Mathod of Disposition	20b. Placa C	ot Disposition (Nama of		Data	20c. Location - Cit	v or Town. Stata
8	1 ☐Burial 2 ☐ Cremation 3 ☐ Ram	10Vel from State	ry, cramatory or other p		14/00		
É .	4 ☐ Donation 5 ☐ Other (Specify)	Ash I	Memorial (cem. I	L/4/00	Sandy S	pring, MD
any in	21. Signature of Funarel Sarvice Licensee	1	22. Nama and Add	Irass of Facility	TIOME	D 7	
8 8	The same of	/ 1,		N FUNERAL			MD 20850
	23a Part Enter the disease or complice	tions that caused the death Do					
-	23a. Part . Enter tha disease, or complications, or heart failure. List only one	ceusa on aach lina.	THO WHEN THE THOUSE OF C	ying, odon do odrado	or raspiratory or		Approximeta Intervel Between Onset end Death
ian							Ondot ond bodin
al er	Immediata Cause (Final disaasa or condition	Respirator	v Failure				
	rasulting in deeth)		consequence ot):				
9		Bilateral	Pneumonia				
E	Sequentially list conditions		consequenca of):				
Examiner	Sequentially list conditions, if any, laeding to immediate cause. Enter Underlying						
g	causa. Enter Underlying Cause (Disease or Injury that initiated events	End Stage	Dementia consequence ot):				
Medical	rasulting in death) Last	Oua to tor as a	consequence or.				
	d	Renal Insu	fficiency				
Physiclan							
Physic	Part II. Other significant conditions contrit	outing to death but not resulting	in the underlying cause	given In Part t.	23b. Dld t	obacco uss contri	buts to the cause of death
f,					101	Yss 2 No 3	Probably 10 Unknow
by							
2							24b. Wara eutopsy tindings
et					репо	med?	available prior to completion of cause
d d					The second		of death?
Completed					1 U Y	res 2 No	1 ☐ Yas 2 ☐ No
Be	25. Was case raterred to medical			26. Placa of Deel	th (Check only o	ne)	
To	axaminar? 1 ☐ Yas 2⊠ No Hos	pital: 15 Inpatient 2 ER/O	utpatient 3 DOA	Other: 4 Nursing Ho	oma 5 Rasio	ianca 8 Othar	(Specify)
	27. Mannar of Death	28a. Data of Injury 28b.	Tima ot 28c. In			now Injury occurred	
10 to	1 Natural 5 Panding invastigation	(Month, Day Year)		/ork7 □ Yas 2□ No			
Cal	3 ☐ Suicide 6 ☐ Could not be	28a. Placa of Injury - At homa, t	arm street teston, offic		28f Location /9	Streat and Number	or Rural Routa Number,
E	4 Homicide determined	building, atc. (Specify)	ami, silvet, tactory, ome		City or Tou	m, Stata)	or ridial riodia redinibol,
edicai Certification:							
cai	29a. Certifier (Check only 2 Medicat Examiner	en: To the best of my knowledger: On the basis of examination as	a, daeth occurred at tha	tima, deta and placa,	and due to tha	cause(s) and mann	ar as stated.
D D	one) 2 Medical Examiner	and mannar stated.	nd/or invastigation, in m	y opinion, daath occur	red at tha tima,	data and place, sno	dua to the cause(s)
completely filled in b	29b. Signatura and itla of certifiar		29c. Lica	nse number		29d. Data signed (i	Month, Dey, Year)
00	Dhu Dhu	Kician	M	50821	1		10/20/10
		F		0-071		- 1	120/0
	30. Nama and addrass of person who comp					1.17	-
	Mofikpara A. Wr	ight, M.D.	1106 Spri	ng St.,	Silver	Spring	, MD 20910
State	31. Data tiled (Month, Day, Year)	32. Registrar's Signetura	1. 1	,			
gistrar	MAY 0 1 2000	L'acres 1	9. Spork	21			



State of Maryland / Department of Health and Mental Hygiene

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		Decedent's Name (F	irst, Middle. La	st)		Cel	uncal	G UI	Death	2. Date of	Reg. No	0.		3. Time of Death
Physician	1			,						Month	Da		Year	
Medica/ Examine:	_	Theresa Ro 4a. Facility Name (If no			ber)			-	4b. City. Town, o	Octob or Location of De		20 c. County		11:22 AM
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eral		5. Social Sacurity Num			Cecil County x 7. Aga (In yrs. last birthday) Under 1			r 1 Year	Elkton Under 24 H	rs. 8. Date of	Cecil Date of Birth Month, Day, Year) 9. Birthplaca (Sta			aca (State or Foreign
ector		204-22-186	8	□M 2 <u>X</u> F	□M 2∏ F 72 Yrs. Months D				Hours M	in. (Month, Septembe	r 19,	1928	Count	ington, DC
	- 1-	Usual Residence of De 10a. Stata 10	cedent b. County		100 CH	y. Town or Loc								
1	- 1						ation					10d. Inside Cit		
Emeral Director	5	Maryland 10e. Street and Number	Cecil		Elk	ton	10f. Zig	Code			T 10- C	alman of th	floor Count	1 ☐ Yes 2 No
i C	5												/hat Count	•
1	0	12 Montgom 11. Marital Status	ery Lan	e 12. Was Deced	lent Ever in 11	S 13 W	219		Hispanic Origin?	/Specify Yes or			State	
100		1 Navar Married	2 Married	Armed For	ces?					(Specify Yes or erto Ricen, atc.)	140		k, White, e	
3	2	3 X Widowed 4	Divorced	If Yes, Give Year or Da	+	1	☐ Yas	2 X No	Specify:			Specify.	Whi	te
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yd befeliad	d	Elementary/Seconda		College (1-	4or 5+)	life. D	O NOT u	se retire	d) d)	vorking				
5	5	10				Waitr	ess							
B G	0	17. Father's Name (Firs	st, Middle, Last)				18. Mother's Name (First, Middla, Maid					Sumam	e)	
F	2	Roy Stepher				Louise Dorsey								
To Re C		19a. Informant's Name	/Relationship (7	Type, Print)		19b. Mailing	g Addrass	s (Street	and Number or	Rural Route Nur	n <i>ber, City</i>	or Town,	State, Zip	Code)
		Duke Pugh 20a. Method of Disposit	N		201 5	28 Due			ourt, No	ew Castl				
		1 ☐ Bunai 2 📉 C	ramation 3 🗆			emetery, crem	atory or o	other pla	ce) Od	ctober 2	3 , 20¢. L	ocation -	City or To	wn, Stata
del	-	4 Donation 5		•	Lav	wn Crof				2000	Lin	wood	Penn	sylvania
once.		21. Signature of Funera	al Service Liber	100		Jo:	Name ar seph	A Addre	ess of Facility Ward Fur	neral Ho	me,	Inc.	145	9 Market
		23a. Part1. Entar tha d shock, or heart fa	y. U	low		St	reet	, Li	nwood,	Pennsylv	ania			
cian lical iner		tmmediata Causa (Fina diseasa or condition resulting in death)	al	a//		to 4 c		PAS	r CA					
edicai Examiner	Evail	Sequentially list conditions, if any, leading to immadiate cause. Enter Undarlying Cause, (Diseasa or injury c.												
as the bunal-transit	בחוכם	that initiated avants resulting in death) Last		Due to (or as a consequance of):										
igned by the ettending be detached for use a by Physician/M	an a			d										
	3310	Part II. Other significar	nt conditions co	entributing to das	th but not res	ulting In the un	derlying o	euse giv	ven in Part f.	23b. D	d tobacco	use con	tributa to	the cause of death?
										1	☐ Yes 2	2□ No	3 Prob	ebly 4 Unknow
									24a W	as an auto	psy	24b. Wa	ra autopsy findings	
Completed	100									D6	riormed?	, -,	con	iliable prior to apletion of ceusa
amo											711	ent.		laath?
		25. Was case referred	to modical									No	1L	Yes 2 No
To Be	2	examiner?	to medical	Hospital:	patient 2	ER/Outpatient	3□ DC	Oth	ner:	eath (Check on		• 🗆		
		27. Manner of Death		28a. Date of		28b. Tima of		28c. Inju		Home 5 Re				9
atio		1 Naturai 5 2 ☐ Accidant	Pending Investigation		, Day Year)	Injury	М		rk? ∣Yes 2∐No					
Certification:		3 ☐ Suicide 6 4 ☐ Homicide	Could not be daterminad	286. Place of	of Injury - At he	ome, farm, stra	et, factory	y, office			(Streat ar		er or Rural	Route Number,
i i											ated.			
dice		one)	Medical Exam	and manne	er stated.	ion and in the	astigation	, in my c	phillon, Gaath oc	ourros at the tim	a, vala all	u piace, a	ind due to	010 00032(0)
Medical				and manne	er stated.	TOTAL DESIGNATION OF THE PARTY		_	se number	ourrou at the tim			(Month, E	
		one)		and manne	er stated.		290	c. Licens		ourou at the tim	29d. Da		(Month, E	

Thomas E. Finucan M.D. 3 Mauldin Avenue, North East, MD

Sporks

32. Registrar's Signature

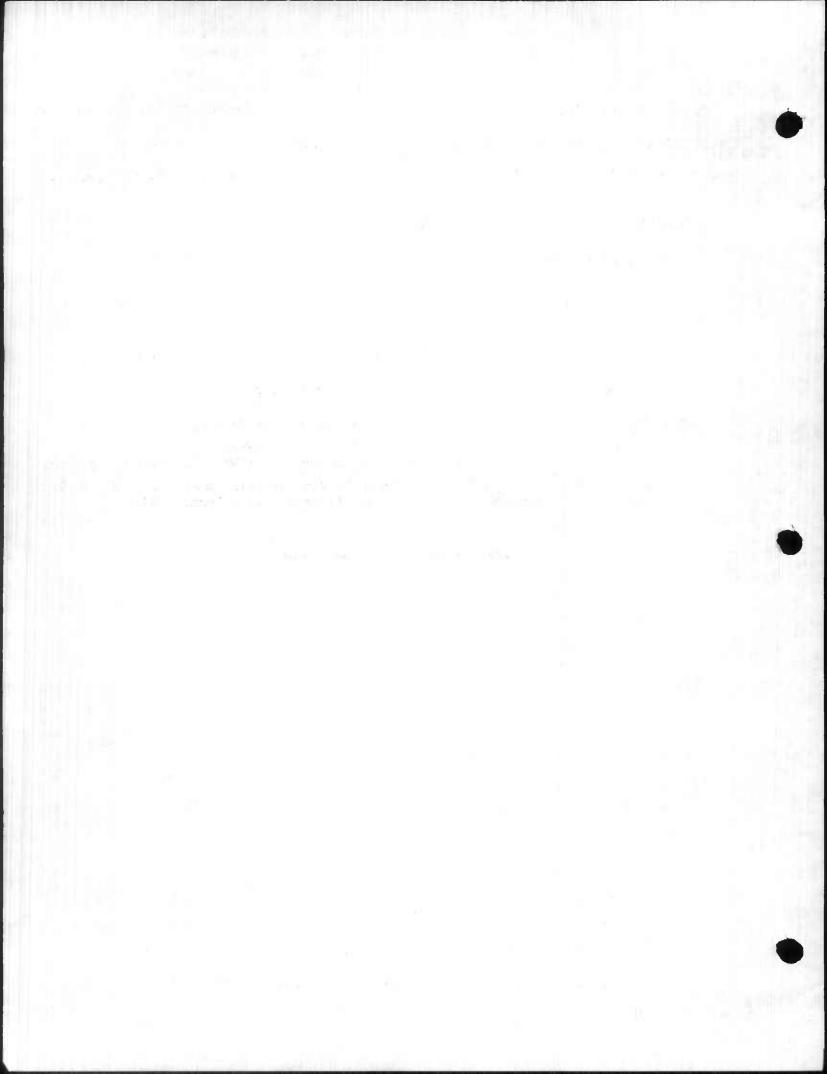
DHMH 16 Ray 6/95

State

Registrar

31. Data filed (Month, Day, Year)

OCT 25 2000



Geraldine Ridgeway

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Dav Month Vear **Physician** Geraldine Wilson Ridgeway 2000 1100 oct /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot The Memorial Hospital Easton If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foraign Country) **Funeral** 10M 20F Deys Months Hours 214 28 1340 67 7/04/33 Director Maryland Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City. Town or Location. 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Mod rail Examinat must be notified at 1 Yes 2 No Director Talbot Md 107 Blake Street Easton 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? with 107 Blake St. Funeral 21601 U.S.A.

14. Raca - American Indien, death 12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus Black, White, etc. 1 □ Never Married 2 □ Merried 1□Yes 2XNo Baltimore, Maryland 21215-0036 Specify: Black þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within Elemantary/Secondary (0-12) College (1-4or 5+) Hyglene. Care Provider Private Sitter 18. Mother's Name (First, Middla, Maidan Sumama) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental Walter S. Young Virgie M. Wilson 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health i Important: If item 27 is any injury or other tra once. Glenwood Ave. Easton, Md. 21601 Donald Wilson (Brother 20b. Placa of Disposition (Neme of cemetary, crametory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Newtown Cem. 11/12/00 Easton, Md. 22. Nama and Address of Facilitiashiell Funeral Service 21. Signature of Funeral Service Licenses 322 East Ave. W Easton Maryland 21601 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** ry Embolism Immediata Ceuse (Final disease or condition resulting in death) /Medical 0 Examiner Dua to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disaase or Injury that initiated evants resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as e consequenca of) 980 for detached Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 200 3 Probably 4 Unknown ð 24b. Were autopsy findings evailable prior to completion of cause of death? been si Completed 24a. Was an autopsy performed? certificata has b lirector, page 2 s 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only ona) To 1 Yes No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Data of Injury (Month, Day Year) funeral 27. Mappar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation death. 2 Accident 1 Yes 2 No Director: A 6 Could not be detarmined 3 ☐ Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 24 hours after Funeral Direct pletely filled in b 4 Homicide The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar es stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the causa(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fi (Check only one) 29d. Date signed (Monthy Dey, Year) 29b. Signature and ittle of certifier 29c. License number 0 30. Name and addrass of page son who completed cause of death (Item 23a) (Type, Print)

Registrar

State

ORIGINAL

Easton,

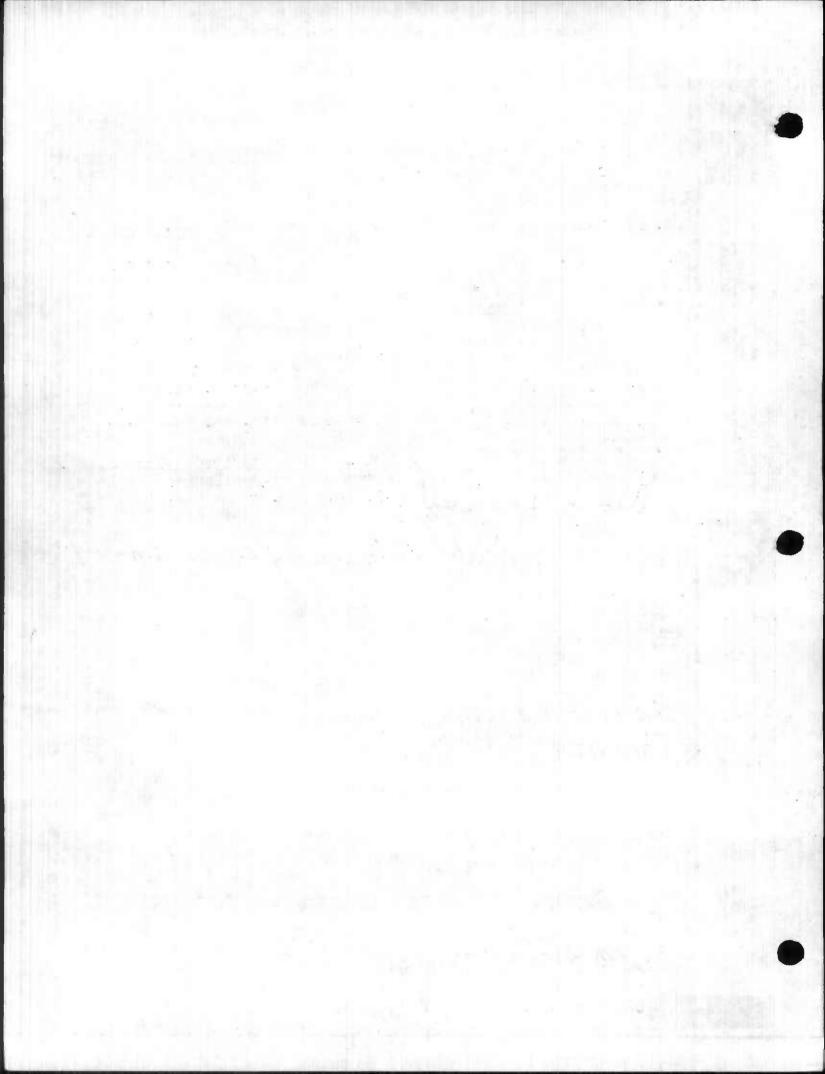
Md. 21601

219 S. Washington St

32, Registrar's Signeture

Allen

Andrea M.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended item#20a, 20b, 20c, (perF.D.) 11/03/00, TCMDertificate of Death Sbb 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month 1:10 A.M Vlable Kobinson 10 2000 /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Nursing + Rehab, Center DENTON
If Under 24 Hrs. 8. C
Hours Min. CAROLINE 6. Se) If Under 1 Year 8. Dete of Birth (Month, Dey, Year) 9. Birthplece (State or Virginio 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** Months Deys 230-42-7315 Usuel Residence of Decedent Yrs. Director 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or itama 23a or 28a-f ahor CAROLINE 1 Yes 2 No Director MARYINAU 10e. Street end Number DENTON 10g. Citizen of Whet Country? 420 USA DR. 21629 Funeral 11. Marital Status Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Rece - American Indien, Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after of the little and Mental Hygiene.
mt: If form 27 is marked other than "natural", or that ury or other traumatic avent, the Medical Expansion ury or other traumatic avent, the Medical Expansion. 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0020 Completed by 3 Widowed 4 □ Divorced Black 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Home MakER Some one Esle's Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surname) Be WesT MARY unk. 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O.Box 381 St. Michaels, Md. 2/663

20b. Plece of Disposition (Name of cometery, crematory or other place)
St. James Cemetery

Ambridge Crematory

22. Name and Address of Facility

22. Name and Address of Facility

23. Name and Address of Facility

24. Name and Address of Facility

25. Name and Address of Facility

26. Name and Address of Facility

27. Name and Address of Facility Ruby Johnson/Grand Daughtee 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Commettee 3 Removel from Stete 4 Donetton 5 Other (Specify) 11/2/2000 Cambridge, maryland permit. Page Department of Important: If any injury or once. 21. Signeture of Funerel Sandar Licensee h Funeral Home Bennie Smith #26 Dover Street, EAS To N, Mary land 21601

or complications that coursed the death. Do not enter the mode of dying, such as cerdiac or respiratory erfest,

Approxim Approximete Intervei Between Onset end Deeth **Physician** /Medical Immediete Cause (Finel 6mo disease or condition resulting in deeth) Examiner Physician/Medical Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760. Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, à Be Completed 24b. Were eutopsy findings evelleble prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? page 2 ZINO Division of Vital To the Hospital or Attanding Physician: 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) 30 Ro Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes this 27. Marrier of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred After 5 Pending within 24 hours after death.

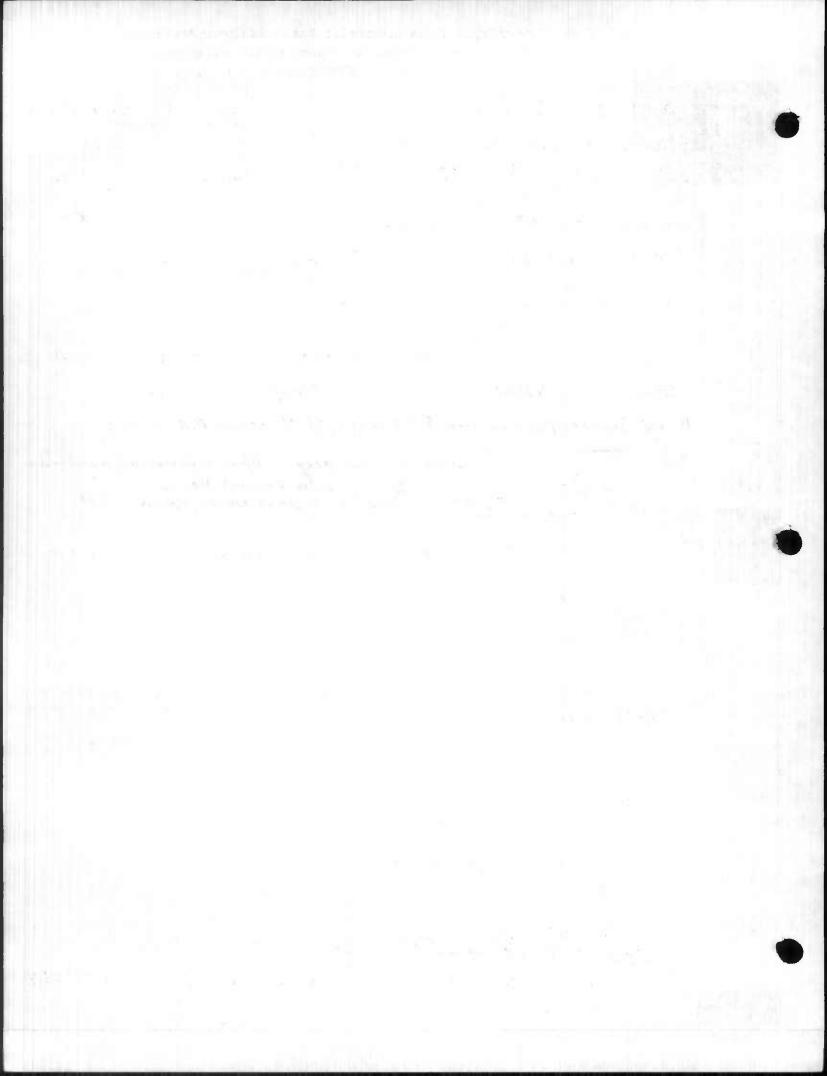
To the Funeral Director: Al
complately filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Sulcide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide dertifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the best of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner steted. edical 29e. Certifier

29d. Dete signed (Month, Day, Year)

Swashergton St Easton mo 2/801

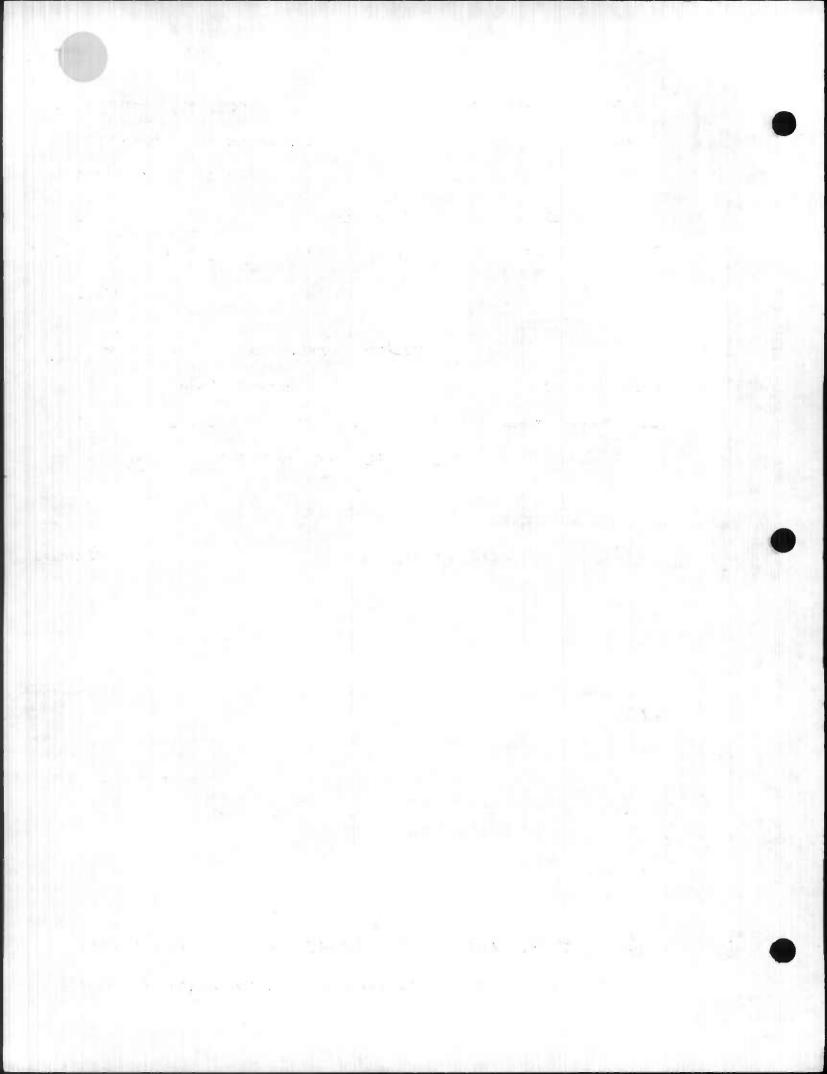
State Registrar 29b. Signature and 1865 of bertilip



State of Maryland / Department of Health and Mental Hygiene

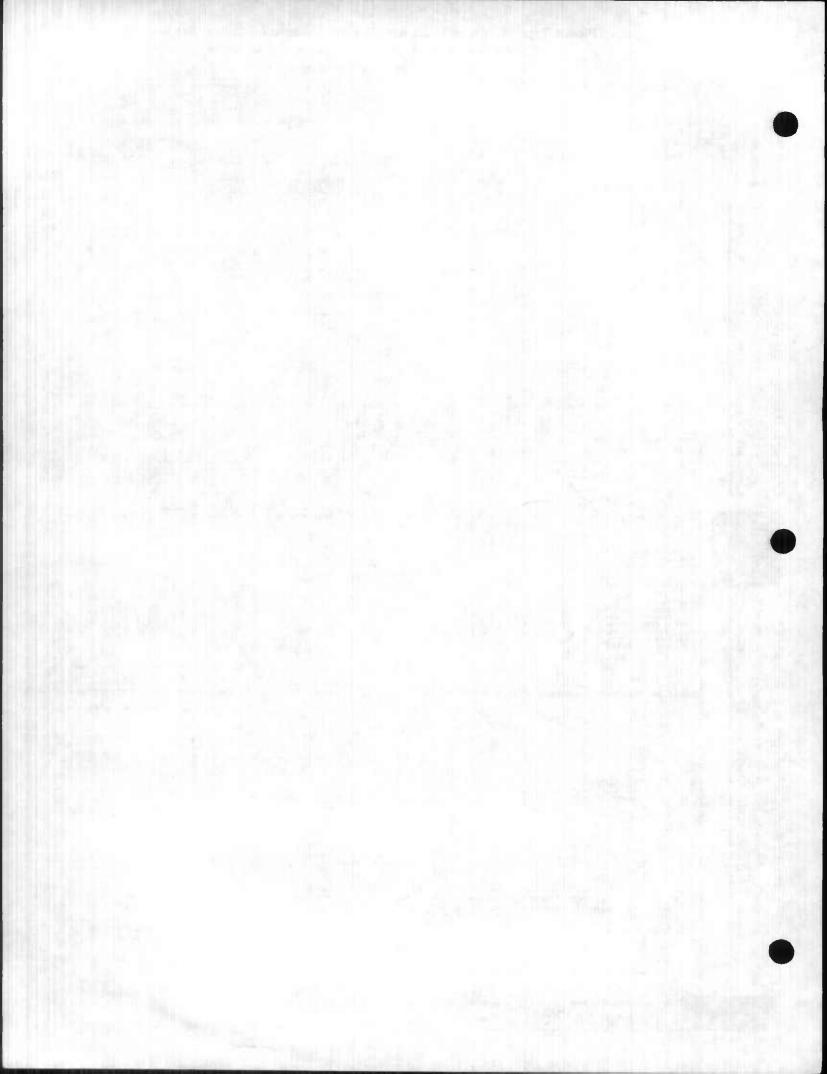
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			Centiti	icate of	Death		Reg	. No.				
	ALVIN R RAGILANII						2. Dete of Deeth Month Dey Yo			3. Tima of Death		
Physician /Medical								31, 2000		10:48 AM		
Examiner	4e Facility Neme (If not institution, give	street and number)			4b. City, Tov	wn, or Location	on of Death	4c. County				
Funeral Director	ll Benwell Ro	ad			Reis	sters	town	BALTIMORE				
	5. Social Security Number 6. Se			Under 1 Year onths Days		24 Hrs. 8.1	Defe of Birth Month, Dey, Y			eca (Stete or Foreign		
	225-76-4953	225-76-4953 NOM 2DF 48 Yrs. Months 1			Hours	J	uly28	y28,1952 Virginia				
	Usuel Residence of Decedent											
alter al	10a. Sfete 10b. County		y, Town or Location						10	d. Inside City Limits		
ler death with the Maryla thems 23e or 28e-f sho frer must be notified at Turneral Director	MD Baltimore Reisterst				own					15√Yes 2□No		
	10e. Street and Number 10f. Zip Co			Of. Zip Code			10g	g. Citizen of Whet Country?				
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her dess inner man	11. Merital Status	12. Wes Decedent Ever in U. Armed Forces?	? If Yes, specity Cuban, Mexican, Puerto				ecify Yes or No- Rican, etc.) 14. Raca - A Bleck, V					
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d within 72 hours at pere. It than "netural", or the Medical Exam Completed by I	3 ☐ Widowed 4 ☐ Divorced	Year or Detes:						Openny				
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Merring Miles To	David Ragland						prings					
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and nath nath	Yvette Green-Ra		1		. Road					21136		
T OF OF	20a. Method of Disposition 1 Derial 2X3 Cremetion 3 DI		Plece of Disposition cometery, cremeto	n (Neme of ary or other ple	ice)	D	ete 20	c. Location -	City or Tow	m, State		
Pag interior	4 □ Donetion 5 □ Other (Specify,	Me.	tropoli	tan F	/Serv	11/2	2/00	Alexa	ndri	a, VA		
amit, Pages 1. Apartment of He mportant: If lise iny injury or oth Bids.	21. Signature of Funeral Service License	169	22. Na	me end Addre	ess of Fecility	у						
88558	# EMAR P	HALAN					HOME,			D 200E0		
	23a. Part1. Enter the the mase, or comp	lications that caused the deet	h. Do not enter th	e mode of dyi	ing, such es	cardiec or re	spiretory erres	KATTI		ID 20850 Approximete		
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Examiner	disease or condition resulting in deeth) 15 Years											
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n an all all all all all all all all all	Sequentially list conditions, if any, leading to immediate	Due to (o	r as a consequen	Ce oij.					1			
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the d	Part II. Other significant conditions contributing to death but not resulting in the underlying cau											
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The law ste has t pege 2 s									of d	eath?		
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Physician: The iave this certificate has rai director, page 2. TO Be Comp	25. Was casa referred to medical examiner?					of Death (C	heck only one)					
2 00 5	1 ☐ Yes 2 ☑ No	Hospitel: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	BDOA Ot	her: 4 Nu	rsing Home	5 Residence	a 8 DOth	er (Specify))		
neral neral	27. Manner of Death 1 ☑Neturat 5 ☐ Pending	28a. Dete of Injury (Month, Day Year) 28b. Time of finjury Work? 28c. Injury et Work?										
Attending or death. ector: After by the fune	2 Accident investigation	M 1 Yes 2 No										
tal or Attending P is after death. al Director: After t led in by the funer Certification:	3 Suicide 6 Could not be determined	208. Place of injury - At nome, farm, street, factory, office										
Pario O	4 Homicide building, etc. (Specify)											
hour hour y fille	29e. Certifier 1 Certifying Phy	sician; To the best of my kno	wledge, death occ	curred et the ti	me, dete end	d place, and	due to the cau	se(s) and ma	nner as sta	ated.		
To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	(Check only 2 Medical Exami	ner: On the basis of examine and menner steted.	tion and/or investi	getion, in my	opinion, deet	th occurred e	t the time, dete	end placa,	and due to	the cause(s)		
Within To th					se number		29d. Date signed (Month, Day, Year)					
0	Steven I. Fil M.D. De			DOM	1D 8		Nor 1, 2000 from, DC 20422					
V	30. Name and address of person who o		23a) /Time Dries	1					1			
	Steven L	. Fish M.D.	CO T.	ing (L Alia	J. 11/2	1.1.	Am A	0 21	1/27		
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State of Maryland / Department of Health and Mental Hygiene 00 36001

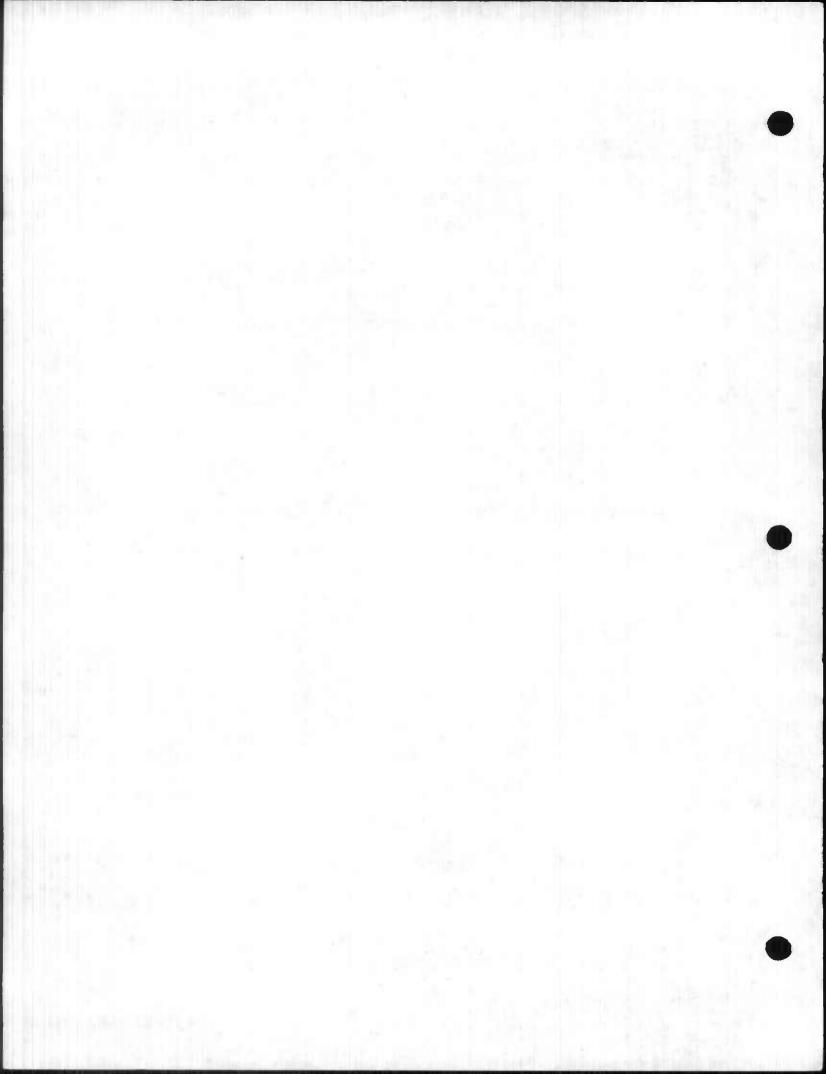
			(Certificat	e of	Death		R	leg. No.		00204	
U.J.	Decedent'a Nama (First, Middle, Last)					2. Date of Month			Death Day Year		3. Time of Death	
Physician /Medical	Barbara R. Rathell					Octol					9:00 AM	
Examiner	4a Facility Name (If not institution, gi	4a Facility Name (If not institution, giva street end number)				4b. City, Tov	wn, or Locat	ion of Death	eath 4c. County of Death			
	Montgomery Hospic		se			Rockv		8 -7				
Funeral Director	005-16-2878	- · · · · · · · ·	7. rigo (ili yra. ladi birtinday) Mantha Davis Maur				Min. De	Date of Birth (Month, Dey ec. 11	of Birth th, Dey, Year) 11, 1921 9. Birthplace (State or Foreign Country) Maine			
I 21215-0020 ed within 72 hours after death with the Maryland yogiene. we than "natural", or items 23a or 28e-f show it, the Medical Examiner must be notified at Completed by Funeral Director	Usual Rasidence of Decedent 10a. State 10b. County		10c. City, Town	or Location							10d. Inside City Limits	
	Maryland Montgomery Rockville							1 ፟ Yes				
	10e. Street and Number 10f. Zip Code							1	ntry?			
	303 Farragut Avenue 20851								es			
	3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes Give		U.S. 13. Was Decedent of Hispanic Origin? (Spe if Yes, specify Cuban, Mexicen, Puerto F 1 ☐ Yas 2 ☑ No Specify:				Rican, etc.) Black, W			can Indian, alc. iite	
	15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usuai Oct (Give kind of work do			during most	of working		16b. Kind of B	idustry		
Man de la composition della co	Elementary/Secondary (0-12)			life. DO NOT use retired)					Newspaper			
Co A th		4	Editor				re Nama /F	iret Middle				
Baltimore, Maryland 21215-0020 semit. Pages 1 and 2 should be flad within 72 hours at Nepartment of Health and Merial Hygiene. mportant: If then 27 is marked other than "netural", or my injury or other traumatic event, the Medical Examinate. To Be Completed by F	Harrison Richardson							(First, Middle, Meiden Sumame) Lovejoy				
	19a, informant's Neme/Relationship							ral Route Number, City or Town, Stete, Zip Code)				
	Edward W. Rathell	/Husband				Avenue			, Mary			
	1 Buriai 2 Cramation 3 Removal from State							7. 2,	, Bethesda, Maryland			
Ball Depart Imports any inja	21. Signature of Funeral Service Consection Robert A. Pumphrey Funeral Home/Rockville, Inc. M00198 Robert Montgomery Avenue Rockville, Maryland 20850-2805											
Physician /Medical Examiner	23a. Part1. Ento ne diseasa, or complications that caused the death. Do not enter tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Immediate Cause (Fine) disease or condition Metastatic Carcinoma									Approximate intervel Between Onset and Death		
	resulting in deeth)	D	ue to (or as a co	ensequence of)	:							
b it c		Lung C	ancer				0.00			1	6 months	
ificate be executed incate be executed in physician and as the burial-transit edical Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):											
M ag		d.										
. D . D	Pert ii. Other significant conditions	contributing to death but	not resulting in	the underlying	ceuse gi	ven in Part i.		23b. Did t	obacco uee co	ntribute	to the cause of death?	
that the detache	Chronic Obstructive Pulmonary Disease						1 🖾 ነ	obably 4 Unknow				
					-		-					
VITAI MECOF. certificate has been rector, page 2 should be Completed	S/P Nephrectomy	H. C	avicle (Pathologic)					performed?		b. Were autopsy findings available prior to completion of ceusa of death?		
	Spontaneous Frac	t Clavi					101			☐ Yes 2☐ No		
						26. Plece	of Death /	Check only o				
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SION OF tending Physically. Its funeral discussion: To continue the funeral discussion of the fu		28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work?							,			
Hospital or Attent 24 hours after deat 24 hours after deat Funeral Director: staty filled in by the dical Certifica	2 Accident Investigation 3 Suicide 6 Could not determined						28	28f. Location (Street and Number or Rurel Route Number, City or Town, State)				
	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the ceuse(s) and menner as stated. (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and menner stated.											
To the vithin To the comple	29b. Signature and title of certifier 29d. Date signed (#							d (Month	Month, Day, Year)			
IV	D09470 October 31, 2000								2000			
	30. Name and eddress of parson who completed cause of death (Item 23a) (Type, Print) Eugene P. Libre, M.D. 10400 Connecticut Avenue, Kensington, Maryland 20895											
State	31. Date filed (Month, Day, Year)	32. Registrar		1	uks							
Registrar	NOV 03 2	000	10	. ppo	uks							



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 26, 2000 Louis J. Rubino October 5:10 PM /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Manor Care Nursing Home Potomac Montgomery If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Yrs 87 Jan 16, 1913 Director Washington, DC 579-01-4201 Usual Residence of Decedent with the Meryland 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23s or 28s-f show any Injury or other traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9808 Carmelita Dr 20854 USA Funeral 12. Was Decedenf Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify þ White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Service Mananger Fuel Oil Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Carmella Fiano John A. Rubino 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Straet and Number or Rural Route Number, City or Town, State, Zip Code) 9808 Carmelita Dr, Potomac, MD 20854 Louis J. Rubino, Jr./Son 20b. Place of Disposition (Name of cametery, crematory or other placa) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremetion 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oct 30 Silver Spring, MD Gate of Heaven Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Hines-Rinaldi Funeral Home ala 11800 New Hampshire Ave, Silver Spring, MD 20904 Wonnell 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on eech line. Approximate Interval Between Onset and Death Physician HEART FAILURE /Medical Immediate Cause (Final CONGESTIVE disease or condition resulting in death) Examiner Examiner physician end the burial-trensit death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical Due to (or as a consequence of): USB 23b. Did tobacco use contribute to the cause of death? detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. of Vital Records, P.O. signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown þ 24b. Were eutopsy findings available prior to completion of cause of death? should l 24a. Was en eutopsy Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 41 Nursing Home 5 Residence 8 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) uneral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After Division 12 Natural 5 Pending Investigation death. 1 Yes 2 No after death Director: / 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Straet and Number or Rural Route Number, City or Town, State) Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours aft To the Funeral DI completely filled in 1 Critiving Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00055200 10/27/00 HYCILIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRIVE GERMANTOWN MD 20874 MURTHY 19504 AN GEETHA DO CTORS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 30 2000 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First Middle Last) 2. Data of Death 3. Time of Death Month SHOCKLEY FRANCES Ε. 30 October 2000 0815 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Talbot The Memorial Hospital Easton If Undar 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Data of Birth (Month, Dev. Year) Birthplaca (Stete or Foreign Country) 1□M 2XF Months Days Hours Min Yrs. 214-12-0257 85 June 25, 1915 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Maryland Caroline Denton 10f. Zip Code 10a. Street and Number 10g. Citizan of What Country? 425 Colonial Dr. 21629 U.S.A. 12. Was Decedani Evar in U,S. Armed Forces? 1 ☐ Yes 2 20 No If Yes, Give Yaar or Datas: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 Never Married 2 Married 1□Yes 2X No Specify: White Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Surneme) Ralph Williams Ida Ward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Marjorie Walbridge Friend 7447 Ocean Gateway Easton, Maryland 21601 20b. Place of Disposition (Neme of cametery, crematory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Olivet Cemetery Nov. 1, 2, 000 St. Michaels, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Servica Licensee Harrison E. Leonard Funeral Home St. Michaels, Maryland 21663 23a. Part1. Enter the disease, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Deeth Immediate Cause (Final disease or condition resulting in death) Mulli Due to (or es e consequence of) Wrosepsi Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying causa givan in Part I. 1 Yas 2 No 3 Probably 4 Unknown 24b. Were autopsy findings 24a. Was an autopsy performed? available prior to completion of cause of death? 1 Yes 2 No 1 □ Yes 2 □ No 25. Was case referred to medical 26. Piece of Deeth (Check only one) Flospital: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 -No 1 12 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of De 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Panding Investigation 1 Naturel 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner Examin

Physician

/Medical

Examiner

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Funeral

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Completed

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Funeral

Director

item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at

"natural", or items

Hygiene.

2 should be a

permit. Pages 1 and 2 Department of Health e Important: If item 27 is any Injury or other tra

Baltimore, Maryland 21215-0020

Shockley

Frances

Physician/Medical by Completed page Be 10 Certification:

been signed by the attending physician and should be detached for use as the burial-transit Division of Vital Records. P.O. Box 68760. certificate has After al or Attanding P s after death. I Director: After 6 To the Hospital o within 24 hours at To the Funeral DI

> State Registrar

DHMH 16 Rsv 6/95

edical

31. Date filed (Month, Dey, Year)

NOV 0 1 2000

29b. Signature and Life of contrior

2 Accident

3 Suicide

29a. Cartifier (Check only one)

4 D Homicide

6 Could not be

Janine Enfalt M.D. 32. Registrar's Signature

30. Neme and address of person wto completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, streat, factory, offica building, etc. (Specify)

ORIGINAL

29d. Date signed (Month, Day, Year) 3010

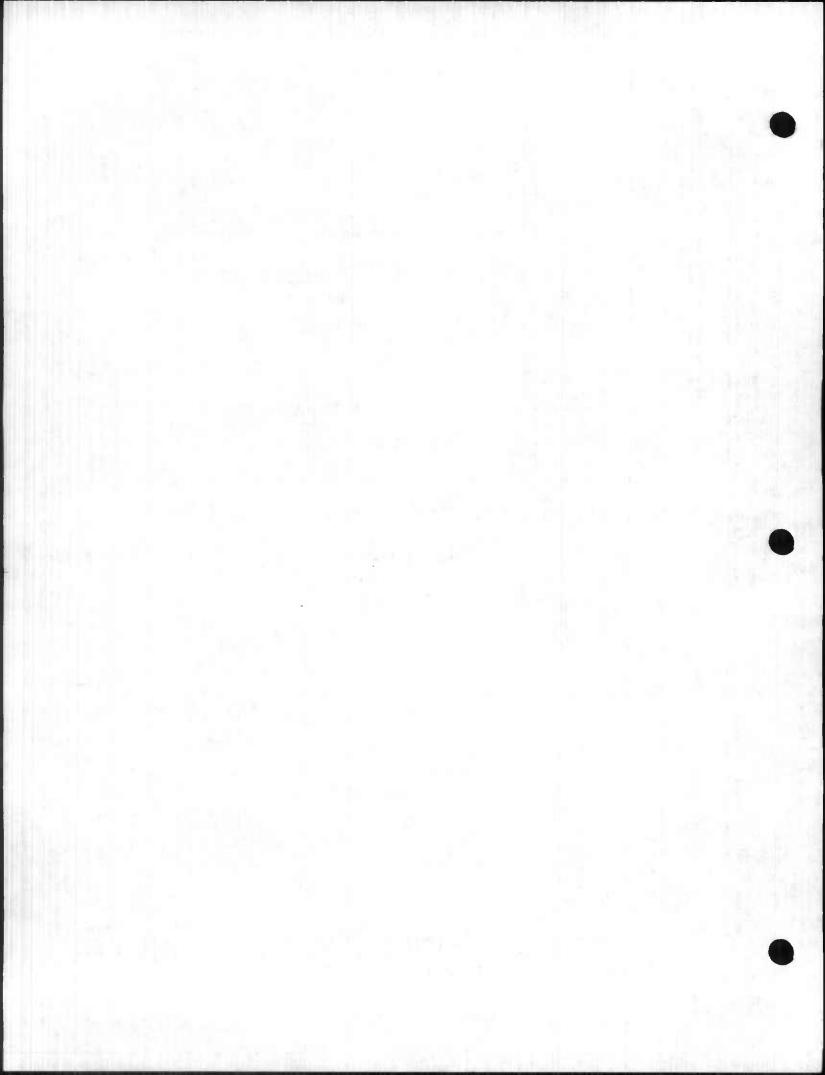
Easton, Maryland 21601

29c. Licansa number

219 S. Washington St.

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and dua to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Streat and Number or Rural Route Number, City or Town, Stete)



State of Maryland / Department of Health and Mental Hygiene 1 3 5 2 3 7

		Otate of Marylar		ertificate o			Reg. No.		0207
Physician	Decedent's Neme (First, Middle, Last					2. Data of Dec Month	Dey	Year	3. Time of Death
/Medical	PAUL W.				1 th 63 Taura	OCT.	1	000	7:30 AM
Examiner	4a Facility Neme (If not institution, give					Location of Death			
	6707 44th			If Undar 1 Ya		ITY PARK			EORGES
Funeral Director	5. Social Security Number 6. Se 197–30–3901 Usuel Residence of Decedent	7. Age (In yrs	Yrs.	Months Da			7. Year) 3, 1942	9. Birthpli	ace (State or Foreign ry) A
pu M	10a. State 10b. County	10c. C	ity, Town or	Location				10	od. inside City Limits
uth with the Marylar 23a or 28a-f show the nounce	MD. PRINCE G	RORCES	1	UNIVERSI	TY PARK				1 ∑ Yas 2 □ No
or 28a-f s	10e. Street and Number	BOLIGES	· · · · ·	10f. Zip Cod			10g. Citizen of W	het Count	ry?
NAME OF THE OWNER.		AVE:		20	782	75.00	11	S.A.	
free death of the feet free free free free free free fre	11. Marital Status	12. Was Decedant Evar in U	J,S. 13		of Hispanic Origin? (uban, Mexican, Pua	Specify Yes or No		- America	an Indian,
urs a	3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yaer or Dates:		1 Yes 2 X		no Hican, etc.)	Specify:	c, White, e	ite.
ed within 72 hours ygiene. er then "neturei", f, the Medical En	15. Decedent's Edu		16a. Dec	cedent's Usual Oc	cupation	42	16b. Kind of Bus	sinass/Ind	ustry
- c	(Specify only highest gred Elementary/Secondery (0-12)	le completed) College (1-4or 5+)	(Gi life	ve kind of work do. DO NOT use ret	na during most of wo ired)	orking			
filed within 72 hours of Hygiene. They then "natural", or mrt. the Medical Exercises.	Liementary/Secondary (C-12)	5+		PROFES	SSOR	71		BOTAN	ΊΥ
			61	-5-310	18. Mother's Ne	me (First, Middle,	Maiden Sumeme)	
d 2 should be file th and Mental Hy 7 is merked oth traumetic event	HAROLD	C. STEINER			1	IRGINIA	WILS	NC	
2 should I sand Menial Sand Me	19a. Informent's Neme/Relationship (T		19b. Ma	iling Address (Stre	et end Number or F	lurel Route Numbe	er, City or Town,	State, Zip	Code)
_ 5 4 % 5	LEILA J. STEIN	ER/WIFE		SAME AS	ITEM #:	LO			
of He	20a. Method of Disposition		Ptace of Dis	position (Neme of remetory or other)	oleca)	Date	20c. Location - 6	City or Tov	wn, State
Pages net of nr; if he ny or o	1 Buriel 2 Tremetion 3 If		CHA	MBERS CRI	EMATORY	10/30/00	RIVE	RDALE	. MD.
permit. Pages 1s Department of Hei Important: if hem any injury or othe	21. Signatura of Funaral Service Licens 23a. Part1. Entar tha disaase, or comp	nlessel MO	0091		FUNERAL I			RDALE	MD.2073
Physician /Medical	shock, or heert failure. List only o	ne cause on each line.	an. Do not e	sites the mode of t	aying, soon as calor	ic or respiratory e	1031,		Interval Between Onset and Death
Examiner	disease or condition resulting in deeth)	a. CARDIAC	DYSRY	THMIA					1 HR.
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ficate be executed physician and style bunal-transit		0. ———		ECURRENT sequence of):	HEAD AND	NECK CAL	RCINOMA		5 MONTHS
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deat d for	Pert II. Other eignificant conditions co	ntributing to death but not re-	sulting in the	underlying cause	given in Part I.	23b. Dld	lobacco use con	tribute to	the cause of death?
ires that the death certification is signed by the attending do be detached for use a discontinuous by Physician Market Clan M						170	Yes 2□No	3 Prob	bably 4 Unknown
aw requ							en eutopsy med?	con	ere eutopsy findings allabla prior to mpletion of cause death?
The law ate has bage 2 s						10	res 2 No	1 🗆	Yes 2□ No
ystcian: The secreticate director, pag	25. Wes case referred to medical				26. Plece of De	eth (Check only o	one)		
Physician: this certific and director.		Hospitel: 1 ☐ Inpatient 2 ☐	ER/Outpat	ient 3□ DOA	Other: 4 Nursing	Home 5 Resid	dence 6 Othe	r (Specify)
ding Ph h. After th funeral		28e. Dete of Injury (Month, Dey Year)	28b. Time	of 28c. I	njury at Vork?	28d. Describe	now injury occurre	ed	
or Attending after death. Director: After 3 in by the fune	1 Neturel 5 Pending investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			☐ Yes 2☐No				
or Attend after death Director: / d in by the	3 Suicide 6 Could not be 4 Homloide determined	28e. Pleca of Injury - At It building, etc. (Special		street, fectory, offi	се	28f. Location (: City or Tox	Street end Numbe vn, Stete)	or or Rure	l Route Number,
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	30. Neme and address of person who co	ompleted cause of death (Ite	m 23a) (Typ	e, Print)					
		ILL, M.D.			Y CENTER	DR #205	GREENEE	L/P X	m. 20770
State	31. Date filed (Month, Dey, Year)	32. Registrer's Sign		JI WILLIAM	- Onlithit	A CASHENA	OLUBIADO.	rest g _ se	m. collo
Registrar	OCT 31 20	00 Deneva	19.	hoors	101				

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 2000 KATHLEEN VERDON SPISAK 8:10AM /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL INSTITUTES OF HEALTH BETHESDA MONTGOMERY If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□ M 2K F Months Days Hours Yrs SEPT. 27, 1967 552-98-8247 33 ROCHESTER.N.Y. Director Usual Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiane. Important: If item 27 is marked other than "natural" any injury or other traumetic excessions. 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1⊠Yes 2 No Directo VA. FAIRFAX SPRINGFIELD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8717 WADEBROOK TERRACE 22153 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates; Was Decedent of Hispanic Orlgln? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College_(1-4or 5+) LOW INCOME PUBLIC HEALTH REGISTERED NURSE 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) JOHN VERDON KATHLEEN BRESLIN 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CRAIG SPISAK/HUSBAND 8717 WADEBROOK TERRACE, SPRINGFIELD, VA. 22153 20b. Place of Disposition (Neme of cemetery, cremetory or other placa) 20c. Location - City or Town, State 20a. Method of Disposition Date Nov. 3, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryrest Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2000 MAHWAH, NEW JERSEY 22. Name and Address of Facility DEVOL FUNERAL HOME 21. Signature of uneral Service Licens 2222 WISC.AVE., N.W. WASH. D.C. 20007 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Severe acute Pulmonary edema /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner melanoma physician end the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lasf Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): 88 esn signed by the atte 23b. Did tobacco use contribute to the causa of death? Pert II. Other algorificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 2 No 1 Yes 3 Probably 4 Unknown p 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy page 2 1 Yes 2 No 2 | No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatienf 3 DOA 1 ☐ Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. edicai 29a. Certifler 29d. Date signed (Month, Day, Year) 29b. Signature and fitle of certifier 29c. License number 291 OC3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) 2000 NOV 01

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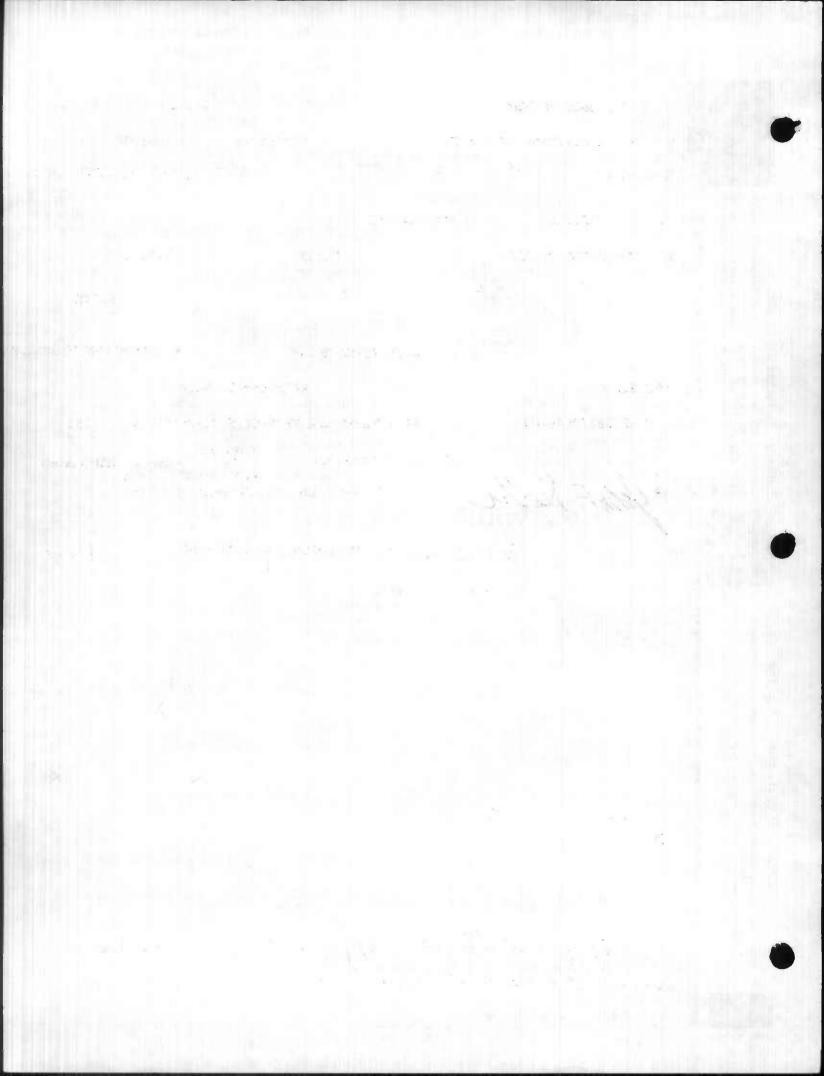
DV 32. Registrar's Signature

9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892

requires that the death certificate be executed

certificate

Division of Vital Records, P.O. Box 68760,

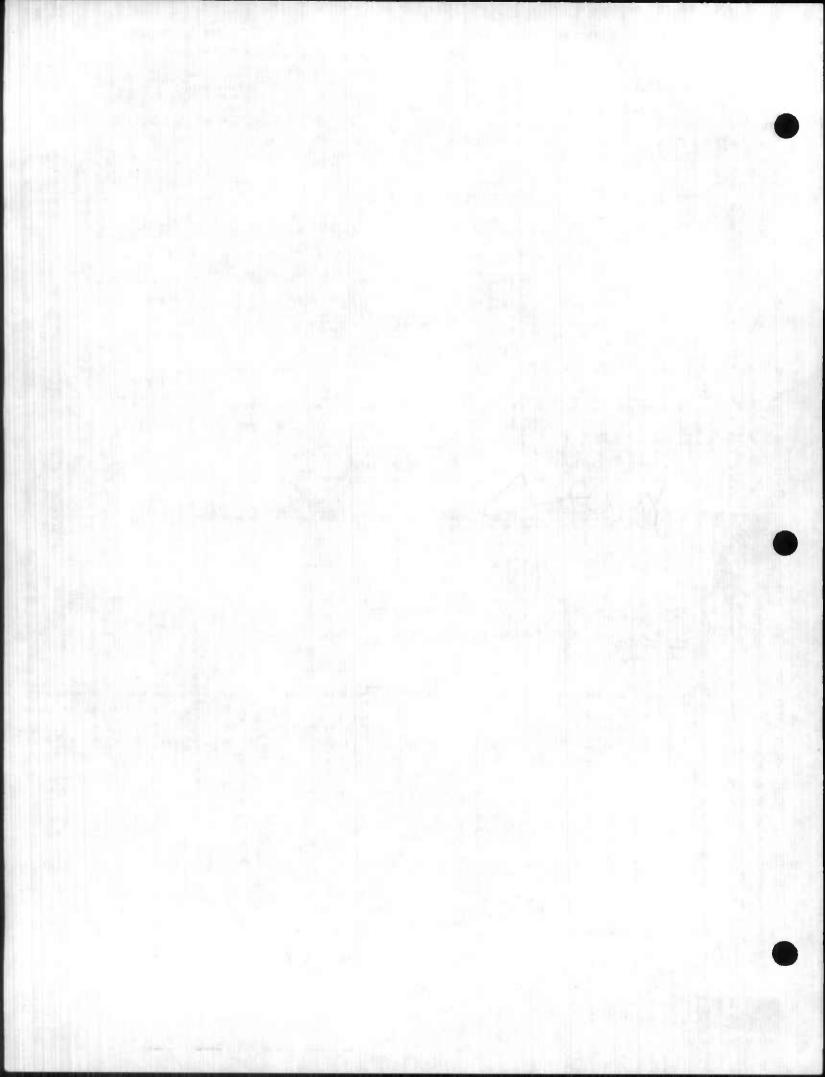


State of Mary

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					Ce	rtificati	e of	Death			Reg. No.	14.11	
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Examiner	4a Facility Name	(If not Institution,	give street end n	um <i>ber)</i>						ocation of Death			
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ahor dat	10e. State	10b. County			Rockvi								10d. Inside City Limits 1 ☐ Yes 2X No
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Director	10e. Street and N					10f. Zip					10g. Citizen of		
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edical	29a. Certifier (Check only				my knowledge, dea examination and/or i								
	one)	TO MACHONICA		anner stal									
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State of Maryland / Department of Health and Mental Hygiene

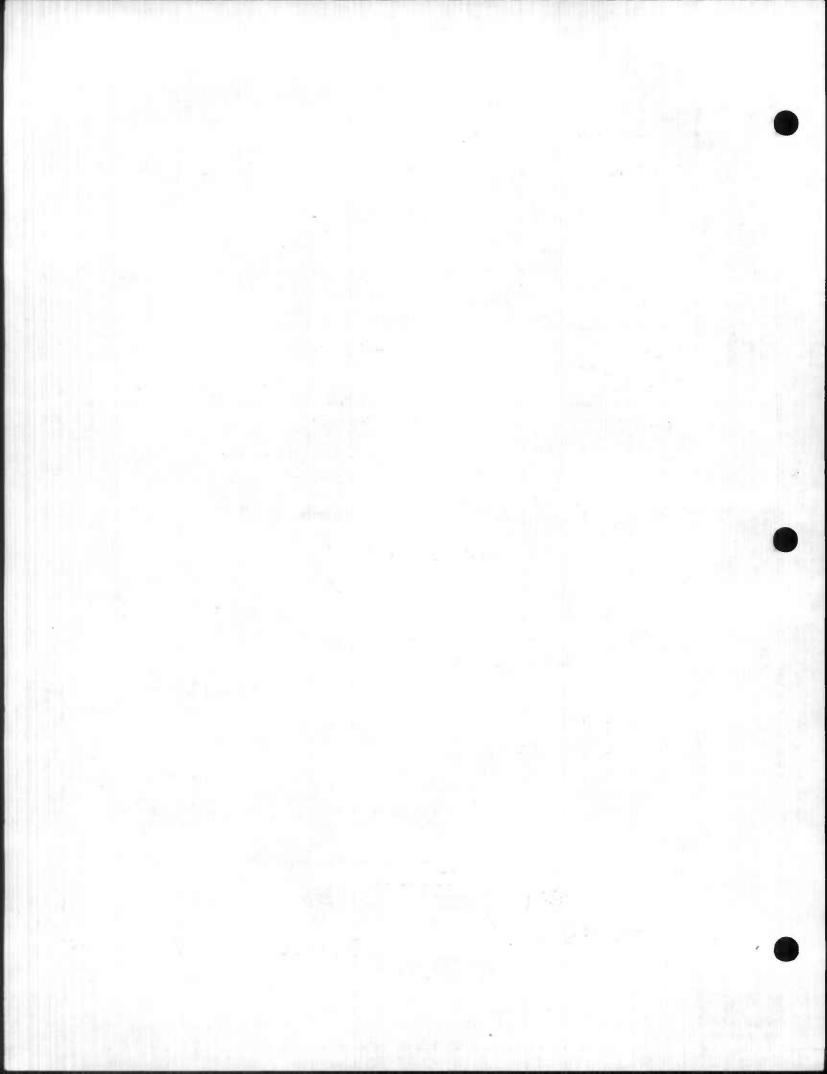
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/Medical Examiner	40 50	cility Neme (# r	RAYMOND not institution, give	A . a street and number	SOKO	LOV		4b. City, To	wn, or Lo	OCT.	27, 2 4c. County	OOO of Death	6:25 AM
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Funeral	5. Soc	ial Security Nur	mber 6. S		ga (In yrs. last		If Undar 1 Year Months Days			8. Data of Birth (Month, Day,	Year)	9. Birthpi Coun	laca (Stata or Foraign try)
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din din		Homicide		building,	atc. (Specify)					City or Town	, Stata)		
DIVISION OF To the Hooptel or Attending Phy within 24 hours efter death To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 7	29a. (Certifier 1 Check only 2 one)	Certifying Ph	ysician: To the bes niner: On the basts and manner:	of axamination	dga, daath o and/or invas	ccurred at tha ti stigation, in my	ima, data an opinion, daa	d placa, a	and dua to tha ce ad at the time, de	usa(s) and me ete end place, s	nner as si and due to	tated. the cause(s)
Vithin To the complete Me		ignature and tit	ta of certifier	01/2 -			29c. Lican	sa number		2	9d. Data signed	(Month,	Day, Year)
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** OCT. 27, 2000 1342 PM ALVAH L. SINGLETON /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital PRINCE GEORGES Laurel If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) July14,1918 7. Age (In yrs. last birthday) 9. Birthplace (Steta or Foreign **Funeral** Days Months Hours M 2□ F 82 Wash. Yrs. 213-16-2369 Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 Yes 2 No Prince Geo. Director MD Beltsville notifie 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? na 23a or WITH 5426 Odell Road 20705 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces?
1⊠ Yas 2□ No If Yes, Giva Year or Dates: 43-45 thems. 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11 Marital Status Black, Whita, atc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Black A 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Security Guard U.S.D.A. 17 Father's Name /First Middle I ast 18. Mother's Nama (First, Middle, Maiden Sumame) Pages 1 and 2 should be III ment of Health and Mental H ant; If hem 27 is marked off lury or other traumatic even Be Mamie E. Singleton Unknown 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Barbara Dodson (Daughter) 8505 Imperial Dr., Laurel, MD 20708 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cremetory or other place) 20c. Location - City or Town, Stata 1XX Burial 2 Cremation 3 Removal from Stata 11/8/00 4 ☐ Donation 5 ☐ Other (Specify) Md. Veterans Cem. Cheltenham, MD 21. Signators of Funeral Service Licensee 22. Nama and Addrass of Facility SNOWDEN FUNERAL HOME, P.A. 20850 lu ROCKVILLE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** /Medical Immediata Causa (Final Respiratory Failure disease or condition rasulting in death) Examiner Due to (or as a consequence of): Examiner Myocardial Infarction physician and the buriel-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Dua to (or as a consequence of): 20 08A Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? of Vital Records, P.O. signed by the 1 Yes 2♥ No 3 Probably 4 Unknown Hypertension Completed by 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Diabetes Mellitus page 2 s has 1 Yes 2 No 1 Yes 2 No or Attending Physician: 25. Was casa referred to medical examiner? Be 26. Piaca of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 8 Othar (Specify) Certification: To 1 Tyas 2₺ No this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 Pending investigation 1 Natural after death. 1 TYas 2 No 2 Accident the 6 Could not be 28f. Location (Street and Number or Rurel Routa Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, atc. (Specify) 2 4 ☐ Homicide filled in Hospital of 24 hours a Funarel D 1 Certifying Physician To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 X Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29e. Certifier Medicai completely (Check only To the within 2 29b. Signature and title 29d. Dete signed (Month, Day, Year) 29c. License number 1 10-30-2000 12 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) 14201 Laurel Park Dr., #110, Laurel, MD German De La Torre, M.D. 31. Data filed (Month, Day, Year) 32. Registrar's Signature State NOV 01 Registrar

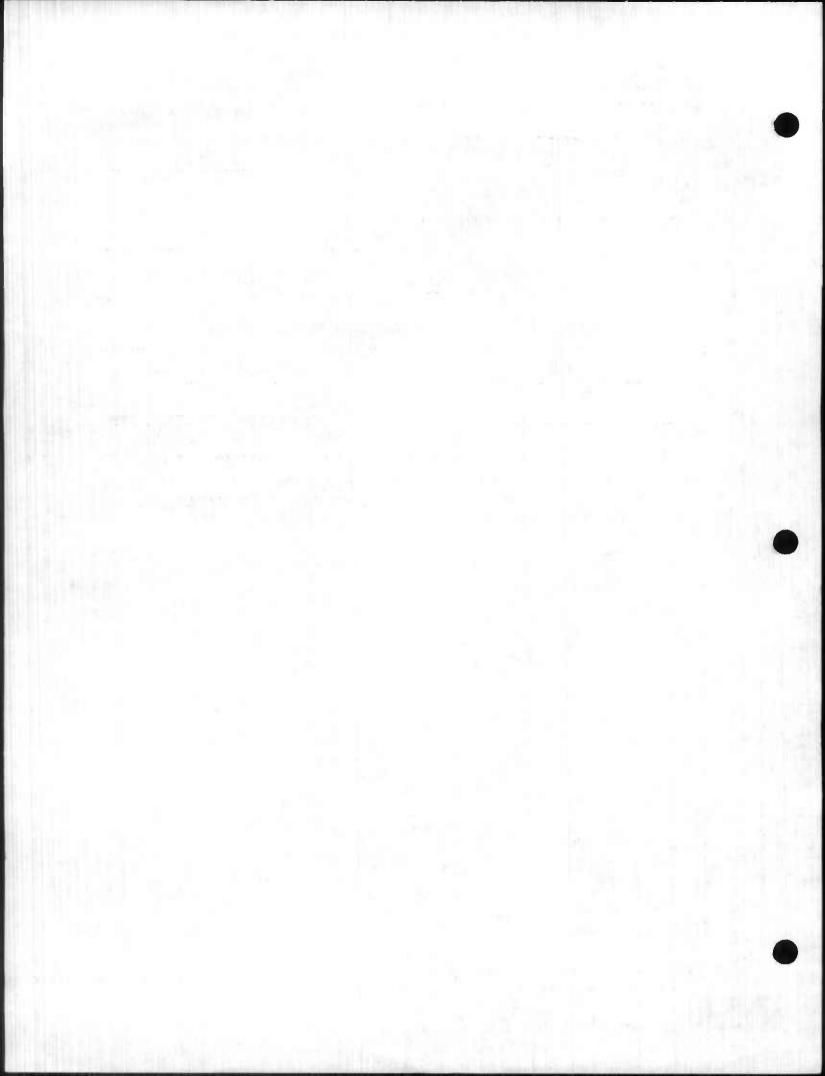


State of Maryland / Department of Health and Mental Hygiene

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Physician /Medical	1. Decedent's Nam	E	LEE	-	MPSON		T	0	2. Date of to	ver 27	2000	3. Time of Death 0658
Examiner	4a Facility Name (f	GTON C	OUNTY H	OSPITAL		William		HAGE	RSTOWN	WA	SHING	
Funeral Director	5. Social Security N 239 26 7 Usual Residence of	7670	6. Sex 1 M 2 □ F	7. Age (In yrs. 79	last birthday) Yrs.	If Under 1 Y	ear ays	If Under 24 Hours	Min. 8. Date of E (Month, I	pay, Year) 1, 1921	9. Birth Cou NOR TI	place (State or Foreign ntry) - CAROL INA
Maryland 4 show lad at	10a. Stata TENN.	10b. County	1.1	10c. Cit	y, Town or Lo HOLLOW			7				10d. Inside City Limits 1 ☐ Yes 2 No
or zila-ta be notified Director	10e. Street and Nut	mber			TIOLLOW	10f. Zip Co	de 342			10g. Citizen		
foer must	11. Marital Status		12. Was De	OCT No.	1	Vas Decedent I Yes, specify	of His Cuban,	panic Origin , Mexican, F	? (Specify Yas or Puerto Rican, etc.)	lo- 14. F	D STATeca - American American American STATECA - American	can Indian,
Exan by	3 🗆 Widowed	4 Divorced	If Yes, G Year or	ive WW		I□ Yes 200		Specify:		Spe	WH.	
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To Be C	17. Father's Name LEWIS	(First, Middle, I	SIMPSOI	V			1		Name (First, Midd EVA MO	le, Maiden Sum ODY	ame)	
r traum	19a. Informant's No		nip <i>(Type, P</i> nint) SON WIF	-					or Rural Route Num DLLOW ROC			
ary or other	20a. Method of Disp	position Cramation	3 □Ramoval from	State 20b. P	emetery, cren	sition (Name of natory or other CEMETI	place,		Date 11/1/00	20c. Location		own, Stata TH CAROLINA
any indi	21. Signature of Fu	uneral Service L	icensee	Barch					ER FUNERA LAYTONSV		D. 208	382
sician	23e. Pert1. Enter ti shock, or hee	he disaase, or ort fallure. List	complications that only one cause on	caused the deat each line.					rdiac or respiratory			Approximete Intervel Between Onset and Death
dical niner	Immediate Cause (disease or condition resulting in death)		a B		R C	ANCE	R					1 YEAR
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igned by the attent be detached for us by Physician	Part II. Other signif	Ronal Condition			-		e giver	n In Part I.		d tobacco use		to the cause of death?
cate has been signed page 2 should be d	_ C,	AROTI	DAR	TERY	STE	NOSI	5			as en autopsy rtormed?	a	Vere autopsy findings vailable prior to omplation of causa f death?
or, page	25. Was case refer	red to medical						00 01		Yes 2 No	1	☐ Yes 2☐ No
I director, page To Be Co	axaminer?		Hospital:	Únpatient 2□	ER/Outpatien	t 3□ DOA	Other		f Deeth (Check on) ing Home 5 ☐ Re		Other (Spec	(64)
4 7	27. Menner of Deat		28e. Date (Mo		28b. Time of Injury		Injury : Work?		28d. Describ	e how injury oc		
al Director: After tiled in by the funera Certification:	3 Suicide 4 Homicide	6 Could n determi	ned 200. Place	e of Injury - At he ding, etc. (Specif	ome, farm, str	eet, factory, of	fice			(Streat and Nu own, State)	mber or Ru	ral Route Number,
he Funer pletely fil edical	29a. Certifier (Check only one)		xaminer: On the						place, and due to the occurred at the time			
Within Comple	29b. Signature and	title of certifier	W			29c. Li	D S	number 23	23	29d. Data sig	28/	, Day, Year)
	30 Name and addr	ase	em 19	414 C		ersbur	9	Pike	Hage	rstou	n n	Naryland
State Registrar	31. Dete filed (Mon		2000	Registrar's Signa	G.	Span	6					



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death **Physician** 2:25 AM NOVEMBER 1, 2000 HARRY M. SHUFELD /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street and number) Examiner MONTGOMERY OLNEY MONTGOMERY GENERAL HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 5. Social Sacurity Number 6 Sex 7. Age (In yrs. last birthdey) Birthplaca (Stete or Foreign Country) **Funeral** Days 15M 2□ F Months 87 Yrs. 100-09-6803 NEW YORK Director SEP 5, 1913 Usual Residence of Decedent with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Insida City Limits r than "natural", or items 23s or 28s-f show the Modical Examiner must be notified at 1 Yas 2 No SILVER SPRING MONTGOMERY Directo 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number 3701 INTERNATIONAL DRIVE #349 20906 USA deeth Funeral 12. Was Decedent Evar in U,S. Armed Forcas?

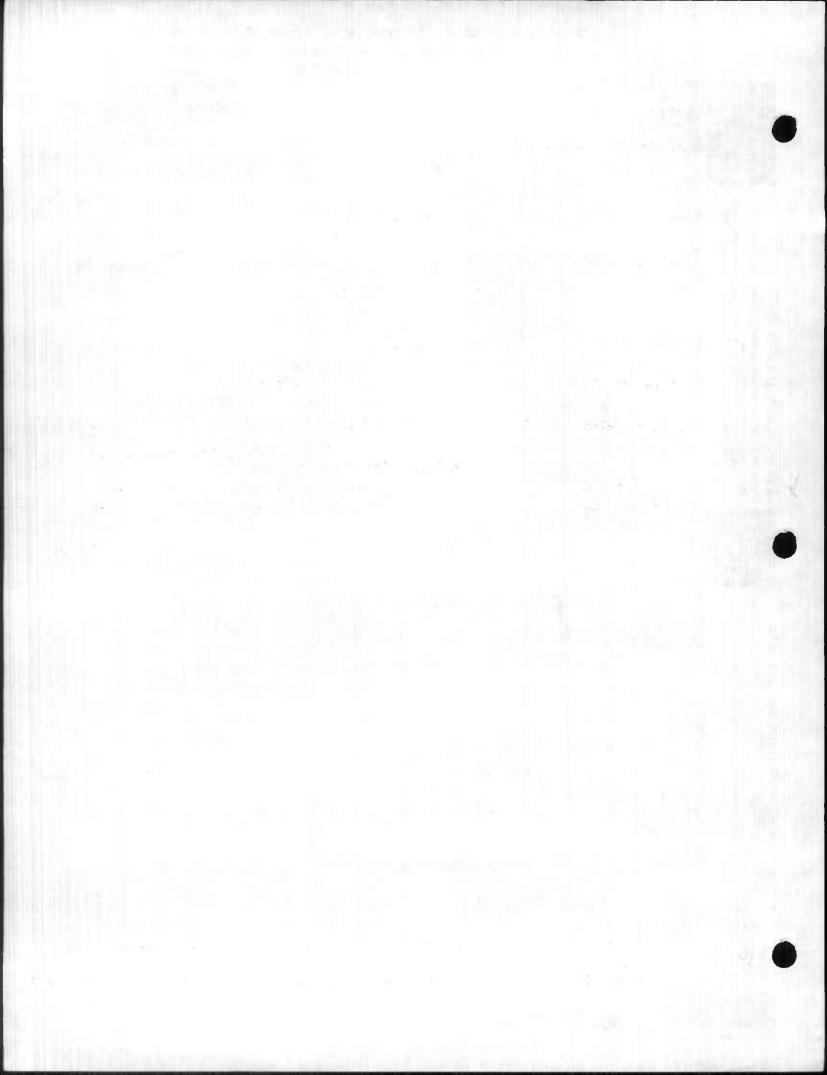
1 Yes 2 No If Yes, Give Year or Dates: 14. Race - Amarican Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 end 2 should be filed within 72 hours efter Health end Mental Hygiene. em 27 Is marked other than "natural", or fte 1 Never Married 2 Married WHITE Maryland 21215-0020 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) 1 2 College (1-4or 5+) US GOVERNMENT PRINTER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Sumama) MARY SOMMER JOSEPH SHUFELD 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 end 2
Department of Health e
Important: If Item 27 Is
any Injury or other trav 3701 INTERNATIONAL DR #349, SILVER SPRING, MD 20906 ROSE L. SHUFELD/WIFE Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition N98082, Burial 2 Cramation 3 Ramoval from State OLNEY, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) JUDEAN MEMORIAL GARDENS Thunsee 22. Name and Addrass of Facility any in EDWARD SAGEL FUNERAL DIRECTION, INC. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approxishock, or heart failure. List only one cause on each line. 20852 Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disaase or condition resulting in death) /Medical **Examiner** Due to (or as a consequence of): Examiner the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last end Due to (or es e consequence of) physician er Box 68760. Physician/Medical Due to (or as a consequence of): 88 for use as 23b. Did tobacco use contribute to the ceusa of death? ed by the e Part ii. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part i. O 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown ۵ that signed t Division of Vital Records. þ The law requires 24b. Ware autopsy findings available prior to should should Completed 24a. Was an autopsy completion of causa of death? page 2 s 1 Yes 2 3 No 1 ☐ Yes 2 No certificate Physician: director, 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospital: Other: 4 ☐ Nursing Homa 5 ☐ Rasidenca 6 ☐ Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this After this 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Certification: a or Attending P safter death.

I Director: After the in by the funer. 1 Naturai 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 - Homicide nin 24 hours aft the Funeral Di npletely filled in Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated.

[] Medical Examiner: On the basis of examination and/or investination in my opinion death accurred at the cause (s) and manner as stated. Hospital edical 29a. Certifier Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) (Check only one) and manner stated. To the I within 2 To the I complet 29b. Signature and 29c. Licensa number 29d. Date signed (Month, Day, Year) 10 30. Name and address o person who completed cause of death (Item 23a) (Type, Print) 12 #211, S.SPRING, MB 20906 MERNATIONAL 5001 32. Registrar's Signatura 31. Date filed (Month, Dev.

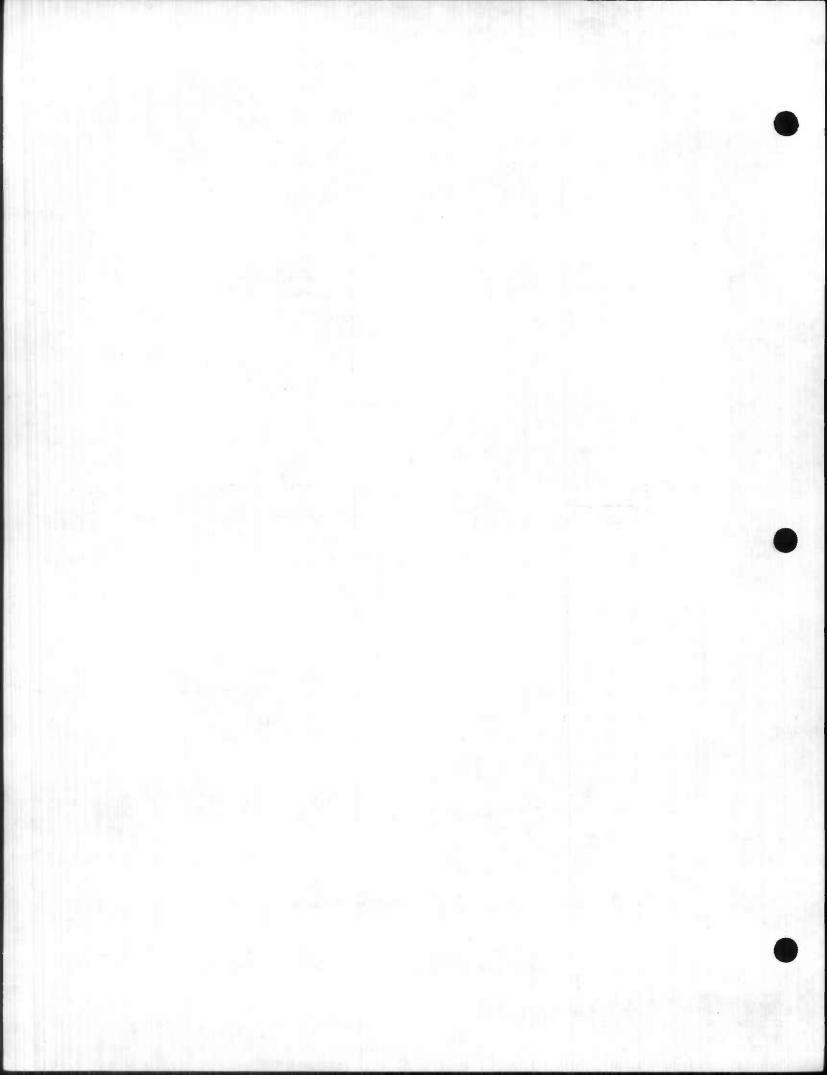
State Registrar

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State of Maryland / Department of Health and Mental Hygiene

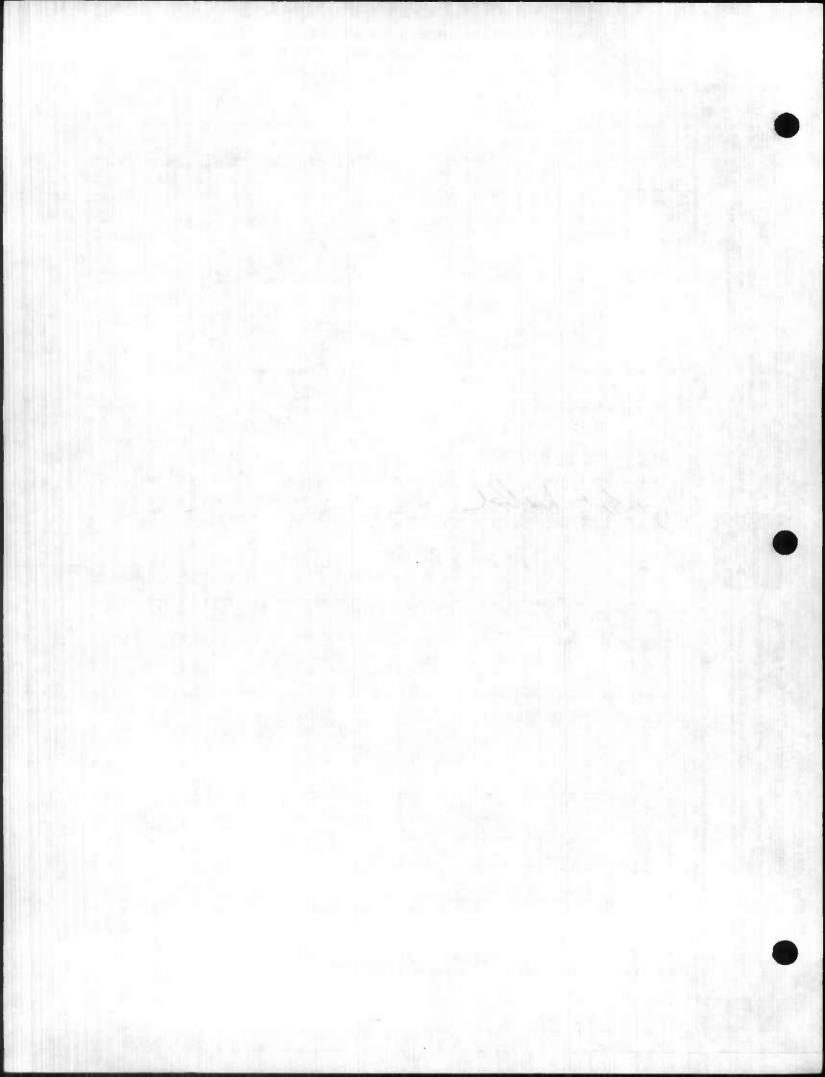
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	me (If not Institution, given	ra street and number)				4b. City, Town, or L	ocation of Death	4c. County	of Death	
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MORRIS							EPSTEIN			
	's Name/Ralationship (and Number or Ru				
ALAN S 20a. Method o	IMMONS / SO)[N	20h Pla	10308		DR., ROCK	VILLLE,		City or Town, St	ata
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17	50	DANIEL SI	MONS	DAN	ZANSKY O ROCK	-GOLDBERG VILLE PIK	MEMORI E. ROCK	AL CHAP	ELS, INC	3.
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Pert II Other	ignificant conditions of	ontribution to death bu	t not recul	ting in the under-	ing cause as	ren in Part I	23b Did	ighacco use co	ntribute to the c	auga of death?
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State of Maryland / Department of Health and Mental Hygiene

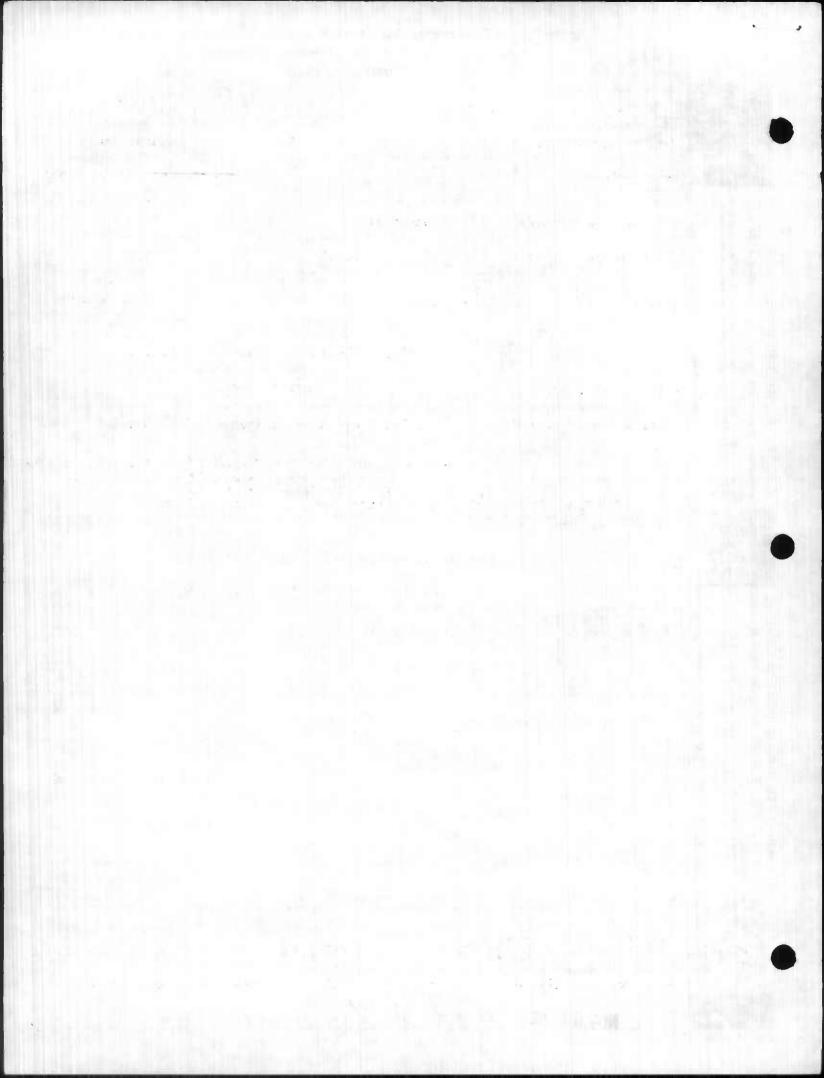
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Funeral	11. Merital Stetus		12. Was Decedent	Ever in U.S.	13. Wes De	cedent of h	Hispanic Ori	igin? (Specif	y Yes or No- an, etc.)			an Indian,	
2	1 ☐ Never M	arried 21 Married	Armed Forces?						an, etc.)	Bla	ck, Whita,		
à	3 ☐ Widowed	d 4 Divorced	If Yes, Give Year or Detes:		1 ☐ Yes	s 2 🖾 No	Specify:			Specif	y: 1	White	
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Be Completed		pecify only highest gra			(Give kind of life. DO NO	work done Tuse retire	during mos d)	t of working					
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0 8	William	n Smith Sh	inn				Mary	Elle	n Grave	es			
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	21. Signature of	uneral Service Lice	nsee //	1						ral Hon	ne 20007		
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	23a. Park Ente	m the disease, or com	plicetions thet caused one cause on each li	the death. D	o not enter the r	node of dyi	ng, such es	cerdiac or r	espiretory err	est,		Approxim Interval B	ate etween
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item#8 perFHG789 11/16/2000 EW Certificate of Death Amend #5,11/9/2000, BMW, Montg. Co. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Desth October 27, 2000 **Physician** 3:20 PM David L. Scott. /Medical 4b. City, Town, or Location of Deeth 4e Fscility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Montgomery General Hospital 01ney Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 1-2-20 (Month, Dey, Year) 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** 1☑ M 2□ F Months Deys Hours Min 80 Yrs. Jan. 4-2 1920 Mississippi Director Usuel Residence of Decedent the Maryland 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Directo Maryland Montgomery Spencerville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Examiner must be r 16515 Brogden Road 20868 IISA Pages 1 and 2 should be filed within 72 hours efter death nent of Health and Mental Hygiena.
Instit if Neur 27 Is marked other than "natural", or items 23, any or other traumatic event, the Medical Examine mainty Funeral 14. Rece - American Indian. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 □3/es 2 □ No If Yes, Give Yeer or Dates1 943-1946 1 Never Married 2 Nerried Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: **Black** by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Chief Mechanical Engineer H.U.D. 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Albert Scott, Sr. Lillie Hodges 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 16515 Brogden Road, Spencerville, Maryland 20868 Willie Mae Scott / Wife 20b. Plece of Disposition (Name of cametery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, State Important: If its any injury or o once. 1 N Buriel 2 □ Cremetion 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify) Gate of Heaven Cemetery 10/31/00 Silver Spring, Maryland 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue (also 23a. Pert1. Enter the disease of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory strest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset end Deeth Physician /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Cardio pulmonary arrest Examiner Examiner Mp to static Prostate Cancer Advanced years physician and the burial-transit The law requires that the deeth certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequenca of) Division of Vital Records, P.O. Box 68760, Heart disease Physician/Medical Due to (or es a consequenca of) as attending for use as TOdays TNEUmonia signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Radiation induced esophagitis þ 24b. Were sutopsy findings sveilable prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? certificate has b 1 ☐ Yes 2K No 1 Yes 2 No Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Monpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funerai 28d. Describe how injury occurred 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury st Work? Certification: After 1 Naturel
2 Accident 5 Pending 1 Yes 2 No death. i or Attendi aftar death. Director: A d in by the fu Investigation 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) To the Hospital or A within 24 hours after . To the Funeral Direct Completaly filled in by 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

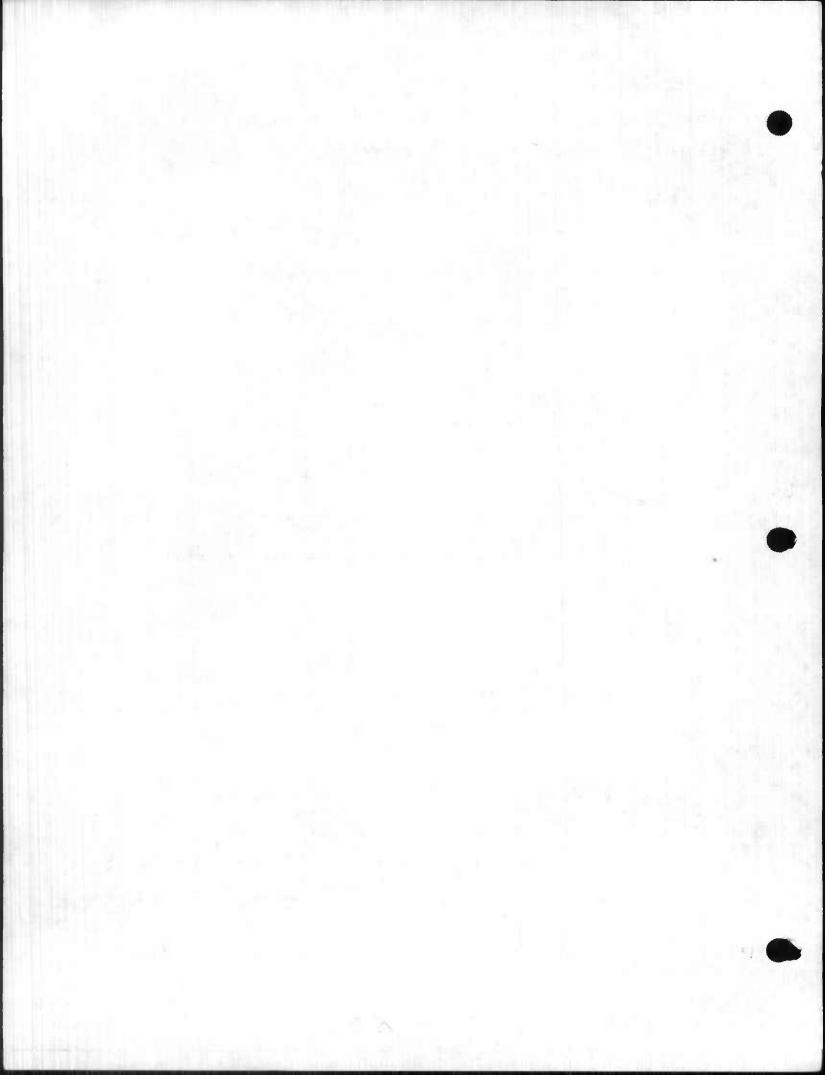
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medical (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number (10) October 27, 2000 D39190 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) J. Garrett Reilly, M.D. 3418 Olandwood Ct., #111, Olney, Maryland 20832 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture sacks 2000 NOV 01 Registrar



State of Maryland / Department of Health and Mental Hygiene

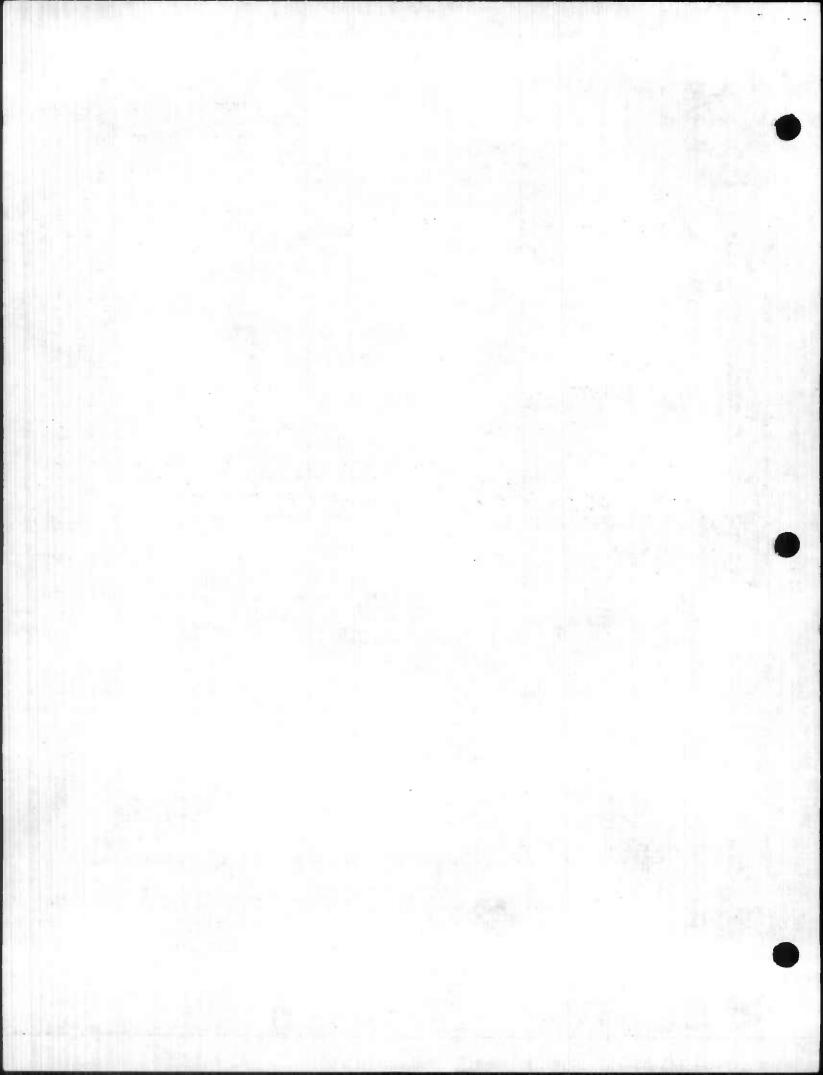
Certificate of Death 2. Data of Death 1. Decedent's Name (First Middle Last) 3. Time of Death **Physician** Oct. 29, 2000 Pear 12:15 AM Norman Sanders /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street end number) 4c. County of Deeth Examiner Manor Care Potomac Montgomery If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 07/15/1922 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** 1□M 2□F Months Days Hours Yrs. 78 098-12-4667 Director Usual Residence of Decedent with the Manyland r 28a-f show 10a. Stata 10c. City, Town or Location 10d. Inside City Limits 10b. County Montgomery Village Md. Montgomery 1 ☐ Yes 2 No Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ir than "natural", or items 23s or 18351 Lost Knife Circle 20886 US Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puarto Rican, etc.) 14. Race - American Indian. e filed within 72 hours after al Hygiena. other than "natural", or ite N☐ Yas 2☐ No If Yes, Give Yeer or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) US Postal Service Clerk 18. Mother's Name (First, Middle, Meiden Sumama) 17. Fether's Neme (First, Middle, Last) Be 2 should be fand Mental It la marked Goldstein Eva Alex Sanders 2 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Itam 27 Ia m any Injury or other traum once. 103-10 Queens Blvd. Forest Hills, NY. 11375 Florence Lichtenberg/ Sister 20b. Place of Disposition (Nama of cemetery, crematory or other plece) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Buriel 2 Cremation 3 Ramovel from State 4 Donetion 5 Other (Specify) 1.0/31/00 Adelphi, Md. Mt. Lebanon Cemetery 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility Edward Sagel Funeral Direction, INC. 1091 Rockville Pike Rockville, Md. 20852 Approximate Interval Between Onset and Deeth 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feiture. List only one ceuse on each line. **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical METASTATIC RESORMAGEAL Examiner Due to (or as e consequence of): Examiner sician and bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequence of) ed by the attending physician detached for use as the buna 68760 Physician/Medical thet initieted events rasulting in death) Last Due to (or as a consequence of) Box 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, p 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was en autopsy performed? Completed this certificate has page 1 Yes 2 No 1 Types 2 TOKNO Division of Vital 8 25. Wes case reterred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Mod Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 10 1 Yes 218 No 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury 27. Menner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? Aftar 5 Pending invastigation 1 Netural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: / 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) illed in by or A 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and mennar steted. 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signeture and title of com-10 10/31/0 H51280 30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print) 13219 Etective Park Terrace German, MD. 20874 DADGA HNUSVITAVA 31. Dete filed (Month, Dey, Year) 32 Registrar's Signature State 2000 NOV 02 Registrar



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State of Maryland / Depar	tment of Health and Mental Hygiene 0 36248
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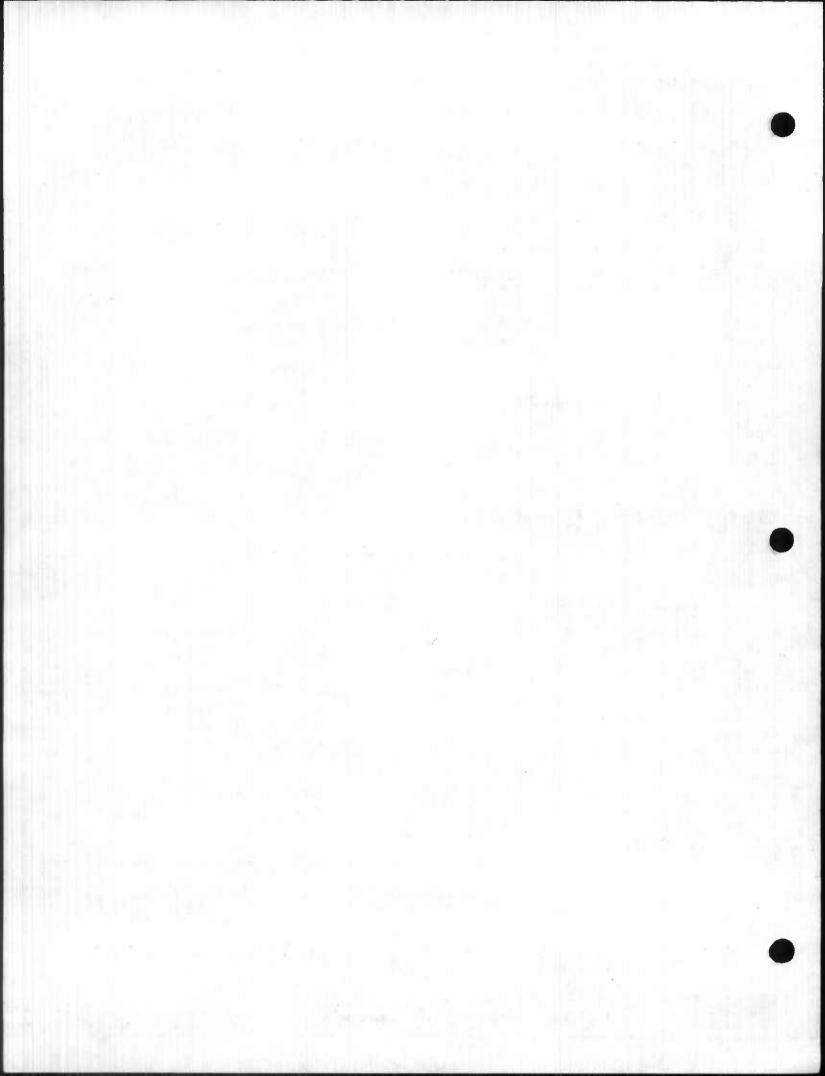
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	IRENA		SALI	JK					Month OCTOBER	29, 20	Year 00	10:10AM
	4a Facility Name (If not institution, g			34			4b. City, To		cation of Deeth	-	of Deeth	
eral		Sex 1 M 20 F	7. Age (In yrs. 92		If Unde Months	or 1 Yeer Days	If Under		8. Date of Birth (Month, Day	h (, Year)	9. Birthp	lace (State or Foreightry)
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edical		Physician: To the aminer: On the bend men										
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	· Ame	nall	u	20		D382	202			October	30,	2000
	30. Nama and address of person what Anurita Mendhira					7	- 16,		Rockvil			



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death Year **Physician** 2:55 Pm trchie October 52000 /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Pleasant View Nuting Home 4101 OH National Pike 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) H Under 1 Year CATTO If Under Months If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Nov. 23, 9. Birthplace (State or Foreign **Funeral** Davs 10M 20 F Hours MD. 86 1913 213-16-1634 Director Usual Rasidence of Decedent 10a Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits must be notified MD. Frederick Frederick 1 □ Yas 2 □ No Director 288-1 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 1431 W. Patrick St. 21703 U.S.A. Berns 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 natural, or 1 Yes 2X No Specify: Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Hygiens. Hygiens. Elamentary/Secondary (0-12) College (1-4or 5+) laborer farm and Mental Hygie Is marked other 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Blanche Routzahn Ira H. Shafer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19s. Informant's Neme/Relationship (Type, Print) spattment of Health, Important: If Item 27 is any Injury or other 2008 8202 Bolivar Rd., Middletown, MD. Gale Cook II (Nephew) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 DABurial 2 Cremation 3 Removal from State 10/27 4 Donation 5 Other (Specify) Reformed Cemetery Middletown, MD. ture by Funghal Service Cicensee 22. Norme and Address of Facility Donald B. Thompson Funeral Home 76 31 E. Main St., Middletown, MD. 21769 alors that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Physician Cerebro Vascular Accident /Medical Immediate Cause (Final 1 How disaase or condition resulting in death) Examiner Examiner physician and the burief-transit Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that the death certificate be execu Box 68760. Physician/Medical that initiated events rasulting in death) Last Dua to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Dementa signed t þ Records, 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 s 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Atlanding Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p. 25. Was case referred to medical axaminer? 8 26. Place of Death (Check only one) Other: Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2N No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28h Time of 28c. Injury st Work? 5 Pending invastigetion 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signeture end title of certifier 29d. Data signed (Month, Day, Year) 10-26-00 D43091 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 801 TOLL HOUSE Are Fredorich, MD SAEED CAIDI MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 16 Ray 6/95

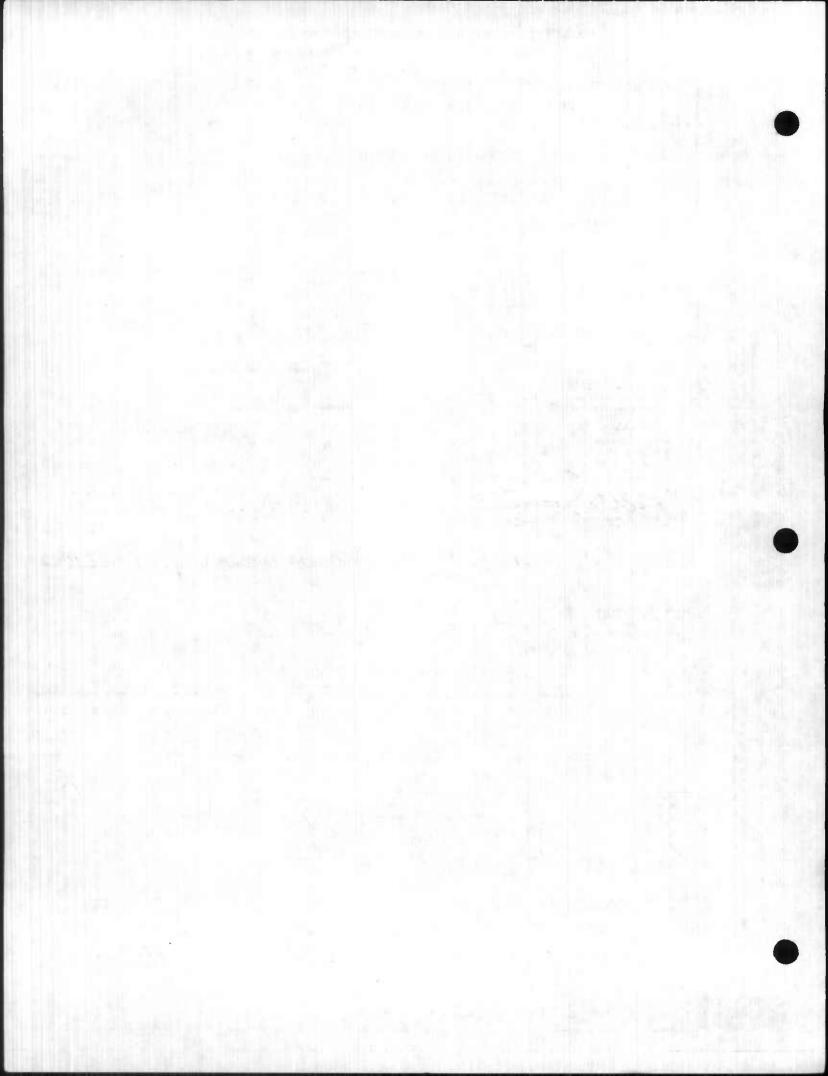


State of Maryland / Department of Health and Mental Hygiene 00 36250

				Cei	tificate of	Death	R	eg. No.		
	Physician	1. Decedent's Name (First, Middle, Las					2. Date of Dear Month October		Year	3. Time of Death
	/Medical	REL	HELEN LOUISE STEINHAUS					-		0340
,	Examiner	4a Facility Name (If not institution, give Citizens Nursing				4b. City, Town, or l Freder:		4c. County Frede		
	Funeral Director	5. Social Security Number 6. Se 214-28-5784	7. Age	(In yrs. lest birthday) 88 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Mooth, Day April 3	, Year) 912	9. Birthple Count Mary I	ace (State or Foreign
	P Au	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation			10d. Inside City Limits		
	with the Marylar a or 28e-f show be notified at Director	Maryland Frederi	ck	Frederic	ck					1 PYes 2 □ No
	or 28e-fa be notified	10e. Street and Number		10f. Zip Code				Og. Citizen of V	What Count	ry?
	23a c	1421 Taney Avenue	Apt. #209		217	702		U.S	.A.	
120	or after dea of, or hams Examiner in Dv Funer	11. Marital Status 1 Never Merried 2 Merried 3 XWidowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ☐ N		Hispanic Origin? (Span, Mexican, Puerto Specify:	14. Rece - Americen Indian, Black, White, etc. Specify: White			
2-0	72 ho	15. Decedent's Edi (Specify only highest grad	15. Decedent's Education 16a. Decedent's Usual Occupation						usiness/Indu	ustry
21215-0020	ed within 72 ho ygiena. ser than "natura. I, the Medical.	Elementery/Secondery (0-12)	College (1-4or 5+) life. i	Homemak	during most of worked)	N''Y	Own H	lome	
Maryland ;	Mertial Hyg rhad other rife event,	17. Father's Name (First, Middle, Last)	n				ne (First, Middle, i ae Stone	Maiden Sumam	10)	
lany	and N	19a. Informant's Name/Relationship (7)	ype, Print)	19b. Mailir	ng Address (Stree	t and Number or Ru	ral Route Number	r. City or Town,	State, Zip (Code)
	Band Banth Mar th	Joy Jenkins (Daug	hter)			Avenue,				
Ore	Pages 1 least of H mt: If her rry or off	20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ I	Removal from State	20b. Place of Dispo cemetery, crer	sition (Name of natory or other pla	ice)	Date	20c. Location -	City or Tov	n, State
altimore	function of the second of the	4 Donation 5 Other (Specify		Mount 01:	ivet Ceme		0/17/00	Frederi	ck, M	aryland
Ba	Depa Impo any i	21. Signatura of Funeral Service Licens	0/			DAILEY &	SON FUN	ERAL HO	MES,	P.A.
	1000	23a Part 1 Enter the disease or com	Seations that caused the	he death Do dot ent	201 NORT	H MARKET	ST. FRE	DERICK,	MD 2	1701 Approximete
8	Physician	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	ne cause on each line		er the mode or by	ing, such as cardiec	or respiretory art	A.		Interval Between Onset end Death
	Physician /Medical	Immediate Cause (Final disease or condition	CA of	Calar	(6	denoces				4 mas
	Examiner	resulting In death)	a. 00	ue to (or as a consec	juence of):	المال مالاحداث	anoma)		11103
	D E									
	ificate be executed growing and as the burial-transit edical Examiner	Sequentially list conditions,	Due to (or as a consequence of):							
68760,	be en ician buria		-							
687	physas the	Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of):								
Box			d							
B	death d for	Part II. Other significant conditions co	ntributing to death but	not resulting in the u	nderiving ceuse g	iven in Part I.	23b. Did to	obacco usa co	ntribute to	the cause of death?
P.0	uires that the death cert signed by the attending of be detached for use deby by Sician/M						1 🗆 Y	aa 2 No	3 Prob	ably 4 Unknown
	bed by									
of Vital Records,	The law requires tale has been sign page 2 should be Completed by							performed? ava		re autopsy findings illable prior to npletion of cause
3ec	has b	DI DESINYEWS							of d	leath?
alF	cate ha						1 🗆 Y		1 🗆	Yes No
VIII.	Physician: The rhis certificate and director, pay		Hospital: 1 ☐ Inpatient	t 2 ER/Outpatier	nt 3 DOA	ther:	th (Check only or		10 4	
			ow Injury occur	ther (Specify)						
ion	Attending or death. Attending by the fune lifecation	1 DNatural 5 Pending investigation	(Month, Day	28a. Date of Injury (Month, Day Year) 28b. Time of thijury M 28c. Injury at Work? 1 Yes 2 No						
Division	tal or Attending P is after death. al Director: After ted in by the funer: Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur- building, etc.	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	Hospi 24 hou Funer tely fill		elcian: To the best of iner: On the basis of e	xamination and/or in						
	within 2 To the comple	29b. Signeture and tille of Certifler	and manner side		29c. Licen	se number	2	29d. Date signe	d (Month, E	Day, Year)
D	F 3 F 8	+ Killy	farfam D-13971 10/16/2000						000	
		30. Name and address of person who co Robert L. Kaufman		ath (Item 23a) (Type, West Nint	Print) h Street	Frederi	ck. Mary	land 21	1701	
		Robert II. Raufillal	, Am 200	WEST NIII	Dereet	, IICUCII	, mary		., 01	

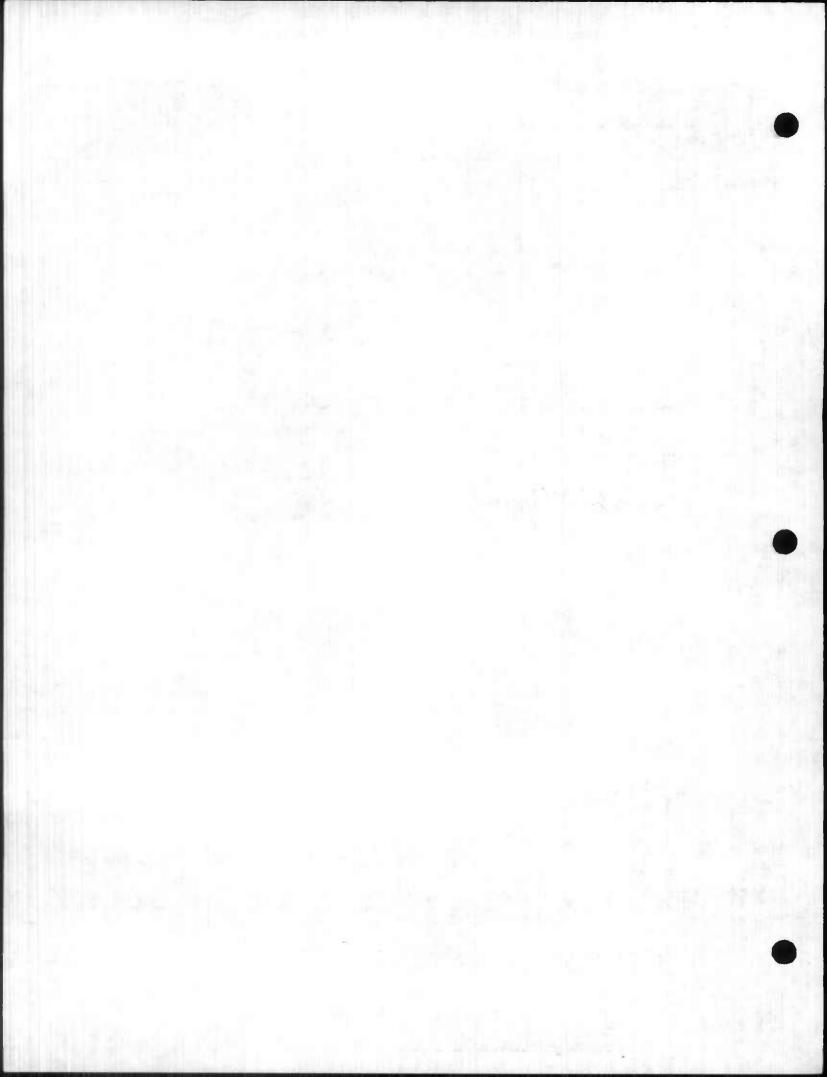
DHMH 16 Ray 6/95

State Registrar



Certificate of Death Reg. No.		
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State of Maryland / Department of Health and Mental Hygiene	00	3625
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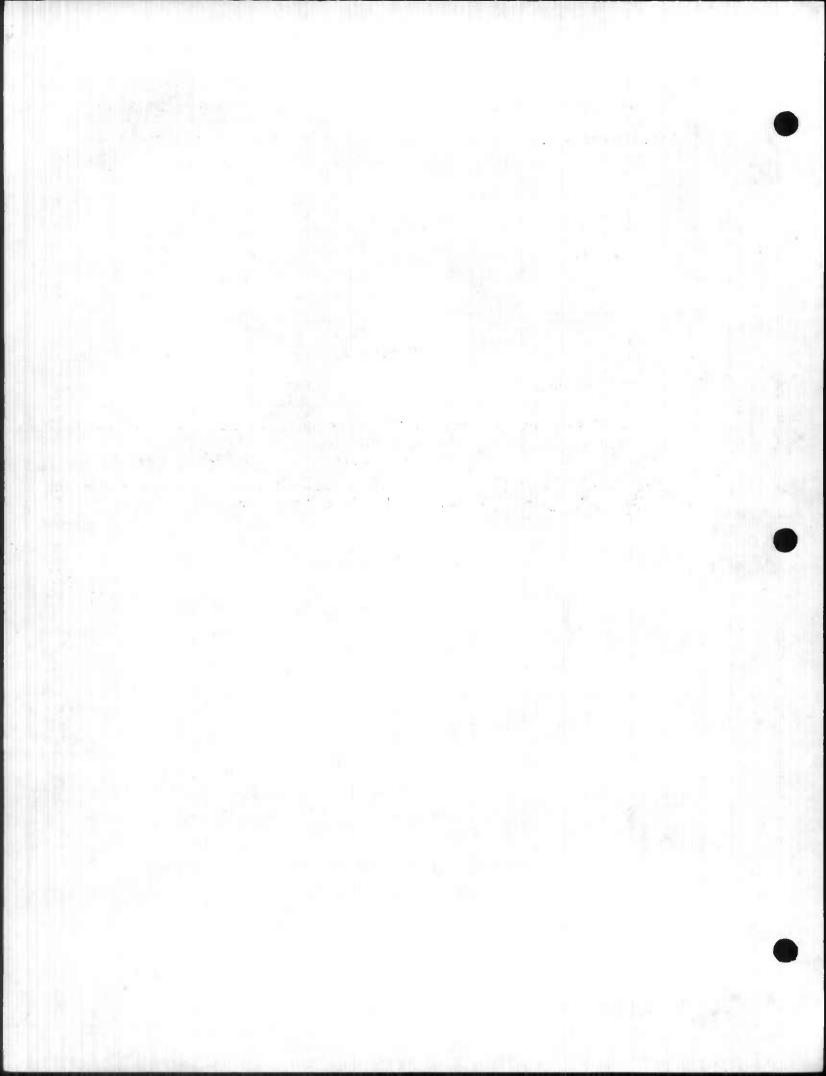
			Certificate of	f Death	Re	g. No.		0 2 4			
THE CASE	1. Decedent's Neme (First, Middle, La	st)			2. Dete of Deeth		Voor	3. Time of Death			
Physician /Medical	MARY	ELIZABETH S	SCHRIDER		OCTOBER	28, 20	ŎÖÖ	5:25 AM			
Examiner	4a Facility Name (If not Institution, giv	e street and number)		4b. City, Town, or I	ocation of Deeth	4c. County o	f Deeth				
22 11	Frederick Memoria	1 Hospital			erick		eder				
Funeral	5. Social Security Number 6. S	TH OFF	Months Dey		(Month, Dey,	Year)		ace (State or Foreign			
Director	578-46-0013 Usuel Residence of Decedent	88	3 Yrs.		June 9,	1912	Mar	yland			
3 8.0	10a. Stele 10b. County	10c. C	ity, Town or Location				10	d. Inside City Limits			
with the Marylan a or 28a-f show be notified at Director											
or 28a-f a be notified Director	10e. Street and Number	TCK AU	10f. Zip Code		10	g. Citizen of Wi	hat Count	ry?			
and by with	2534 Monocacy Bot	tom Dood	,	1710		United	C+-	****			
her death v r Reme 23s siner must.	11. Merifel Stetus	12. Wes Decedent Ever in U			pecify Yes or No-	14. Race	- America	an Indian,			
	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☒ No		o Rican, etc.)		k, White, etc.					
Dy Eres	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Detes:	1 ☐ Yes 2 ☒ N	o Specify:		Specify:	Wh	ite			
Maryland 21215-0020 3 should be tilled within 72 hours at th and Merital Hygiene. The marked other than "natural", or treumstic event, the Medical Exam To Be Completed by it	15. Decedent's Ed (Specify only highest gra		16a. Decedent's Usuel Occ	upetion	kina 1	6b. Kind of Bus	iness/Ind	ustry			
21 Mee	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work don life. DO NOT use reti	red)	n i g						
Co Con Co	12		Homemak			Own H					
Be seen	17. Father's Neme (First, Middle, Last,			18. Mother's Nar	ne (First, Middle, M	eiden Sumeme)				
yla Menta Menta Menta To	Oliver Thomas Van	Horn			ine McKay						
A Sah	19e. Informent's Neme/Reletionship (Type, Print)	19b. Maiting Address (Stre	et end Number or Ru	irel Route Number,	City or Town, S	Stete, Zip	Code)			
CTNF	Rosemary Baugher/	Daughter	2534 Monocac Plece of Disposition (Name of cemetery, cremetory or other p	y Bottom	Road, Ada	mstown,	Md	21710			
Or of the per of the per of	20e. Method of Disposition 1 ☑ Burlel 2 ☐ Cremetion 3 ☐	Removel from Stete	cemetery, cremetory or other p	lece)	Dete 2	Oc. Locetion - C	or Io	wn, State			
altim nit. Pa artmen ortent: injury	4 □ Donetion 5 □ Other (Specif	r) Re	sthaven Memori		s10/31 I	rederic	ck, N	Maryland			
Baltimore, emit. Pages 1 a hoparment of Hei mportant: If from ny injury or othe frice.	21. Signeture of Funerel Service Licer	11	22. Name end Add	,	D A E		TY				
m 405 s a	Jodel Olynur Olin L. Molesworth P. A. Funeral Ho 26401 Ridge Road, Damascus, Marylan										
	26401 Ridge Road, Damascus, Maryland 20872 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one Lause on each line. Approximata Intervel Between Onset and Death										
Physician											
/Medical Examiner	Immediate Cause (Finel disease or condition	· Mar		Sdays							
	resulting In death)	Due to (or as a consequence of):				1				
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and Hran	Sequentially list conditions,	ntielly list conditions, Due to (or es e consequence of):									
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. Box 68760, death certificate be executed e attending physician and od for use as the burial-transit	thet Initiated events resulting in death) Last	Due to (Due to (or as e consequence of):								
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is, P.O. Box is that the death certigened by the attending be deteched for use a by Physician/M											
	Pert tt. Other significant conditions of	ontributing to death but not re-		3b. Did tobacco use contribute to the cause							
that the detection of Physics Application of the detection of the detectio	Cerebousen	les aux	len	1 U Ys	1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 1 Unkno						
Records, P.O. he law requires that the hes been signed by th sge 2 should be detech ompleted by Phys	1 ~.				24a. Wes en	eutopsy	24b. We	ere autopsy findings			
v require been s should	dementra				perform	ed?	COF	aliable prior to appletion of cause			
The law requirements have been spage 2 should Completed		0 (/				-56		desth?			
	slegue 1	Resordes			1 🗆 Ye		1 [_	Yes 2□ No			
of Vital Re Physician: The in this certificate he ral director, page i: To Be Com	25. Was case referred to medical examiner?	Hospitel:		Other:	ath (Check only one						
Physic this c ral dire	1 Yes 2 Alo	1 □ Inpatient 2 Ц	DENOUIPATION 3LI DON	4 Li Nursing r	lome 5 Resider)			
E grand o	1 Neturel 5 ☐ Pending		28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et 28d. Describ Work? M 1 □ Yes 2 □ No					is the many described			
isideat deat deat ctor: y the	3 ☐ Suicide 6 ☐ Could not b				28f. Location (Street and Number or Rural Rou		l Route Number.				
Division of teal or Attending P rs after death. al Director: After the led in by the funers Certification:	4 ☐ Homicide determined	289. Piece of injury - At nome, ferm, street, fectory, office				City or Town, State)					
	29a. Certifier 110 Certifying Ph	fying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.									
he Hospin 24 hound he Funer pletely fill			ation and/or Investigation, in my								
within on the comp	29b. Signeture and fitle of certifier	- 1	29c. Lice	nse nu <i>m</i> ber	29	d. Date signed	(Month,	Dey, Year)			
F 3 F 0	Di	4/16/	mn n	30491		10/28	1200	10			
	30. Neme and address of person who	completed cause of death (Ite	m 23a) (Type Print)	30496 1 St; 1-	-	1001					
	F- 6 1	eshes ma	300 W 9+A	157.6	referen	1. m/	21:	701			
State	31. Dete filed (Month, Dey, Year)	32. Registrer's Sign	eture A			1.04	-, ,	,			
Registrar	OCT 3	2000	is a popular	ocks							



State of Maryland / Department of Health and Mental Hygiene

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				Certific	ate of	Death		Reg. No.			
	Decedent's Neme (First, Middle, Last)						2. Dete of D	2. Dete of Death 3. Time of Death			
hysician /Medical THELN	HINDELMA WILLIE SHOWALARD						ber 24		6:25pm		
	e (If not institution, gi	ve street and number	7)			4b. City, Town	n, or Location of Dec	th 4c. Count	y of Death		
15 Ri	verview	Rd.				Chesa	peake Ci	ty Ce	ci1		
5. Social Securi 206-12	2-3315	Sex 7. A 1 □ M 2/2 F	ge (In yrs. last b	Yrs. If Ur Mont	hs Days	If Under 24 Hours		1925	9. Birthplec Country, PA	ce (Stele or Foreign	
Usuat Residence	e of Decedent		10c City To	wn or Location					104	. Inside City Limits	
									100.	1 Ves 2 No	
FL 10e. Street and	Brevai	rd Co.	Cocoa	a Beac						10	
212 (Curacau D				Zip Code 3293			U.S.A	•		
3 □ Widow	Aarried 2 TXMerried and 4 □ Divorced	12. Wes Deceden Armed Forces 1 Tyes 2 K If Yes, Give Yeer or Detes	[No			lispanic Originan, Mexican, Specify:	n? (Specify Yes or N Puerto Rican, etc.)	Io- 14. Rad Ble Specif	ce - American ock, White, atc. fy: Whi		
Elementery/S	15. Decedent's E pecify only highest gra	ducation	16	a. Decedent's L	Jsuei Occup	ation during most o	of working	16b. Kind of B	usiness/Indus	itry	
Elementery/S	econdary (0-12)	College (1-4or	5+)	life. DO NO	T use retire	during most o					
8 12				Nurse	s Aid				th Car	ce	
17. Fether's Ne	me (First, Middle, Last				2.0		s Name (First, Midd		ne)		
e Edwar	d Collis	on				Grad	ce Sheid	Y			
	s Neme/Ralationship ((Type, Print)	19	b. Meiling Add	ress (Street	and Number	or Rural Route Num	ber, City or Town	, Steta, Zip Co	ode)	
Bertr	am Showal	lter (h	usband) 212	Cura	cau D	r. Cocoa	Beach	, FL.	32931	
20a. Method of			20b. Place	of Disposition (Neme of		Dete	20c. Location	- City or Town	, State	
	2 Cremation 3 ☐ on 5 ☐ Other (Special		9	Crem			10/25/	00 Smy	yrna,	DE.	
	Fugural Service Lice	**	110111			ss of Fecility	10/23/	oo om	I mu /	DE.	
		7011	/	Gale	na Fu	neral	Home o	f Steph	nen Sc	haech	
()			10 510	118	West	Cros	s St. G	alena,		1635	
Boa. Part En	Approximete Indicates or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Interval Between										
,			,	,					O	Inset and Death	
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rasulting in dea	th)	0.	1 1	s consequence	of):					3. 0	
Sequentially lis											
Sequentially lis	t conditions.	b	Due to (or as a	consequence	of):						
	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or Injury c.										
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Cause (Disease that initieted every resulting in dea	Due to (or es e consequence of):										
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Part II. Other sl	military and the	matellustine to don't	hash mark may relate	In the contest of		one in the sale	001 51	d tobacco ···-	antellante de co	he course of death C	
Part II. Other St	Part II. Other eignificant conditions contributing to death but not rasulting in the under								acco use contribute to the cause of death?		
	Hypothyroid						11	Yes 2 No	3 Probab	bly 4 Unknown	
A p	1,						24a Ws	is an autopsy	24b. Were	autopsy findings	
9							per	formed?	availa	able prior to pletion of cause	
Completed								. /	of dea	aen?	
3							10	Yes 2 No	1 🗆 Y	res 2□ No	
	eferred to medical					26. Place o	of Deeth (Check only	one)			
	No	Hospitel: 1 Inpat	ient 2 ER/C	Outpatient 3	DOA Oth	er: 4 Nurs	sing Homa 5□Ra	sidence 8 XOti	THAT (SUBDITIVE)	AUGHTERS	
		28a. Deta of In (Month, D	ury 28b	. Time of	28c. Injui	y at	28d. Describe how injury occurred HOME				
	2 Accident investigation 3 Suicide 6 Could not be 28e. Plece of Injury - At home, ferm, street, fectory, office						0				
3 Suicide						28f. Location					
4 Homici	4 ☐ Homicide building, etc. (Specify)						City or 1	City or Town, Steta)			
	Certifying Pt	nysician: To the best	of my knowledg	a. death occur	red at the tie	me, date and	place, and due to th	e cause(s) and m	annar as state	ed.	
29a. Certifier (Check only	2 ☐ Medical Exam	miner: On the basis of	of examinetion a	ind/or investiga	tion, in my o	pinion, deeth	occurred at the time	a, data and place,	, and dua to th	a cause(s)	
-	and title of certifier	and mornial s			29c. Licens	e number		29d. Date signe	ed (Month, Da	iv. Year)	
(0		12-1			
1	4 Jan	Ul MS			13	351	U	10	157/	00	
30. Name and a	ddress of person who	completed causa of	death (Item 23a	_		λ.		, /)	10-		
Timo	Ths 0.1%	DNNEIL	Vuito	32 K	oples	PUZA	Glas 600	JAG	1410	12	
ate 31. Date filed (onth! Day, Year)	/32. Regist	trer's Signature	1	1						
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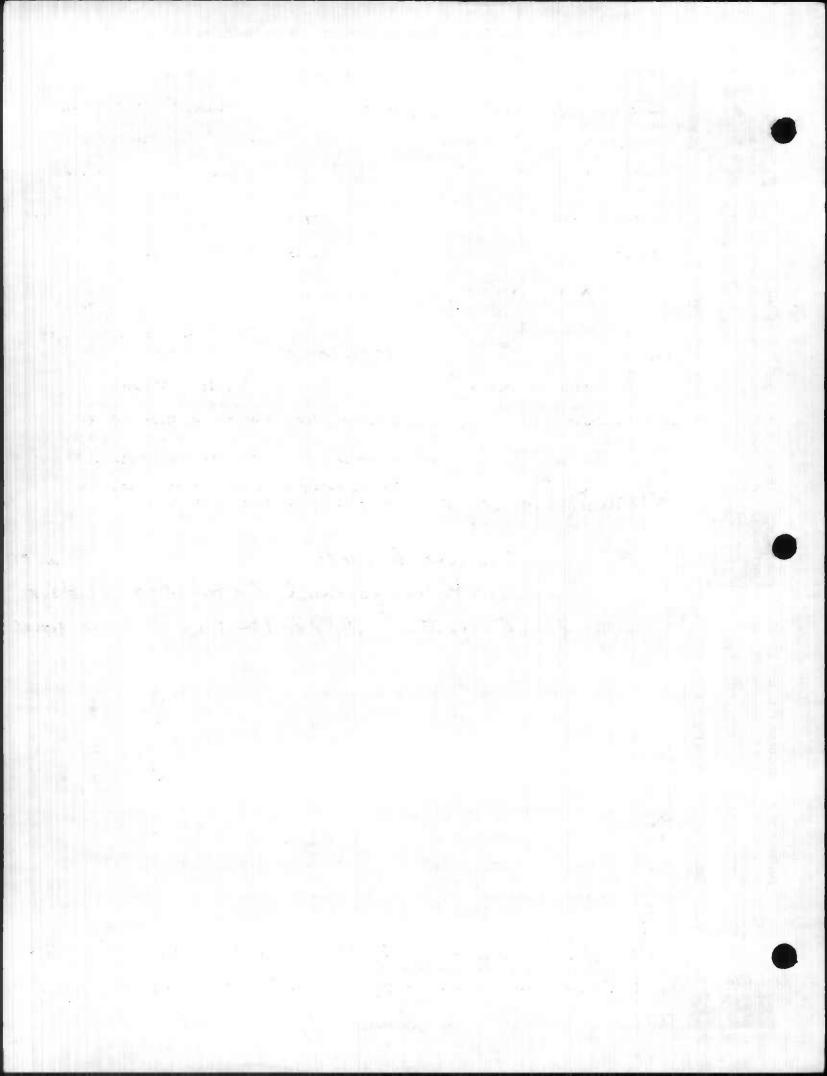


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State of Maryland / Department of Health and Mental Hygiene 3 6 2 5 3

State of Maryland / Department of Health and Mental Hygiene	е
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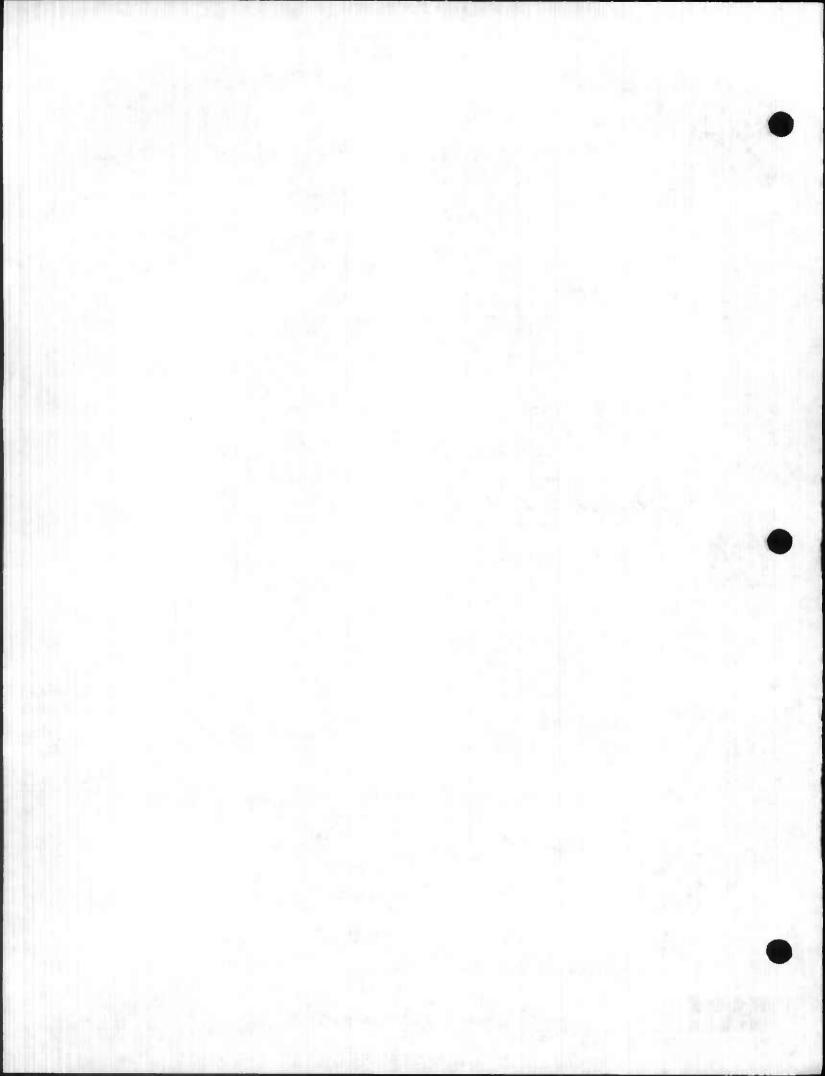
	1. Dec	cedent's Name (First, Mid	ddle, Lasi	1)						2. Data of Da		Vac-	3. Time of Deeth	
Physician /Medical		JOHN	Ho	wava	15	mo	vse.			Octob	er 27, 2	Year 2000	9:56 pm	
Examiner	4a Fa	cility Name (If not instituti	tion, giva	street and nun	nber)				•	Location of Deat		y of Death		
		Montgomery							01ne			ntgo		
Funeral Director	2	ial Security Number 12-38-8094	6. Se	X M 2□F	7. Age (In yr: 80	s. last birthde Yrs.	Months		If Under 24 Hrs Hours Min.	(Month, D	th ay, Year) 1,1920	9. Birth Cou M	place (State or Foreign ntry) aryland	
3	Usual 10a, 5	Residence of Decedent State 10b. Coun	ntv		10c. C	City, Town or	Location						10d. Inside City Limits	
28s-f shownorthed at rector		ryland (Ceci	1					yville				1 ☐ Yas ZÇNo	
23a or 2	1	Reservoir F	Road				10f. Zip		903		10g. Citizen of U . S	What Cou	ntry?	
al, or tame 23a or 28a-f s Example rough be noutled by Funeral Director	10	arital Status ☐ Never Married 2 Me ☐ Widowed 4 ☐ Divorce		12. Was Dece Armed Fo 1 M Yes If Yes, Giv Year or De	rces? 2 No	If Yas, specify Cuban, Mexics No 1953-58 If Yas, specify Cuban, Mexics 1□ Yas 2∏ No Specify			panic Origin? (S Mexican, Puar Specify:	pecify Yes or No o Rican, atc.)	0- 14. Ra Ble Speci	ick, Whita,	can Indian, , atc. White	
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er traur		1da R. Smous				33	Reservo	oir R	oad, Pe		e, Mary	Land	21903	
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important: it any injury or ance.	21. Signature of Funeral Sarvice Licensee 22. Name end Address of Facility Lee A. Patterson & Son Funeral Home Perryville, Maryland 21903-0766											ome,	P.A.	
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State of Maryland / Department of Health and Mental Hygiene 1 1 26251

			Cert	ificate of	Death	Re	g. No.	, 0	ULU"		
	1. Decedent's Neme (First, Middle, La	st)				2. Date of Death Month	Day	Yaar	3. Time of Deat		
ysician Medical	IR	VING ELMER T	HOVIPSON			October	0.5	000	1035		
aminer	4e Facility Name (If not institution, give	e street and number)			4b. City, Town, or L	ocation of Death	4c. County	of Deeth			
	The Memorial				Easton	1		bot			
neral	5. Sociel Security Number 6. S	TXM OF E	last birthday) Yrs.	If Under 1 Year Months Days		8. Dete of Birth (Month, Dey.	Year)	Coun			
ector	220-07-7404 Usual Residence of Decedent	77				Jan. 15	,1923	Penna	a		
=	10a. State 10b. County	10c. Cit	y, Town or Loca	ation				10	Od. Inside City Lin		
ideal Exercine must be notified as	Maryland Talbot		Bozman						1 □ Yes 2X		
Director	10e. Street and Number		DOMINAT	10f. Zip Code		10	g. Citizen of V	Vhet Coun	lry?		
B C	8090 Bozman Rd.			21612			U.S.A.				
Funeral	11. Merital Stetus	12. Was Decedent Ever in U Armed Forces?	,S. 13. W	as Decedent of Yes, specify Cut	Hispenic Origin? (Span, Mexican, Puert	pecify Yes or No- Rican, etc.)	or No- 2.) 14. Rece - Am Biack, Whi				
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	17. Father's Name (First, Middle, Last,			DOOKKE	-	ne (First, Middle, N					
Be		Leroy Thompson				ola Mae (0)			
J.	19e. Informant's Name/Reletionship (Address /Stree	et and Number or Ru			State. Zip	Code)		
	Chester W. Mott			Box 957		Maryland			,		
To Be Comp	20a. Method of Disposition			tion (Neme of story or other ple			Oc. Location -		wn, State		
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BeC	25. Was case reterred to medicel				26. Place of Dea	ith (Check only on	3/				
To B	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 DOA O	ther [A	ome 5 Reside		er (Specif	y)		
	27. Manner of Death	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury		ury at ork?	28d. Describe ho					
Certification:	1 Neturel 5 Pending 2 Accident investigatio	n	injury		Yes 2□No						
tific	3 Suicide 6 Could not b	28e. Plece of Injury - At h building, etc. (Specif	ome, tarm, streety)	et, fectory, office		28t. Location (Sti City or Town	ocation (Street and Number or Rural Route I ity or Town, Stete)				
Ce											
edical	29a. Certifier 12 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best of my kno niner: On the basis of examina end manner stated.	owledge, deeth outline and/or inve	occurred et the testigetion, in my	time, dete and plece opinion, death occu	, end due to the ce rred at the time, da	use(s) and me ate and plece,	end due to	tated. the cause(s)		
2	29b. Signature and title of certifier	end manner stated.		29c. Licer	nse number	25	9d. Dete signe	d (Month,	Dey, Year)		
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	20 Name and addison to	u onu	4	(Amina)	7123	4	10	1 d	11200		
	30. Neme and address of person who	DeSheilds M.			ld Ave. E	aston Me	arvland	2160)1		
State	31. Dete filed (Month, Dey, Year)	32. Registrer's Signa		101011	- 1110. D	CO COLL, IN	and I will		-		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** 2110 November ELEANOR CLARK TOWERS 2000 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Memorial Hospital Talbot Easton If Under 1 Yaar If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1□ M 25 F Deys Hours Min. 65 Yrs JAN 21 1935 Director MD 220-32-1779 Usuei Residence of Decedent the Maryland 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Medical Examiner must be notified at 1 Yas & No Director TALBOT TRAPPE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29739 BARBER RD. 21673 USA Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Detes: Wes Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - Amarican Indian. 11. Merital Status Bleck, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 No Maryland 21215-0020 Specify: Specify: WHITE p 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 11 BUS DRIVER PUBLIC SCHOOL SYSTEM 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be should be WILLIAM WALLACE CLARK MARY ELIZABETH HAMMOND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) permit. Peges 1 and 2 Department of Heelth a Important: If item 27 is any injury or other tree 4119 WHITELEYVILLE RD., HURLOCK, MD 21643 DEBORAH L. TOWERS/DAUGHTER 20a, Method of Disposition 20b. Pieca of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Cremation 3 ☐ Removei from State 4 ☐ Donetion 5 ☐ Other (Specify) 11-05-00 CORDOVA, MD FAIRVIEW CEMETERY mud Funeral Service Licenses 22. Neme end Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST, EASTON, MD 21601 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Fine) disease or condition resulting in death) Examiner Due to (or es Examiner physician and the burial-trensi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events icate be exec Box 68760 attending physician Physician/Medical that initiated events resulting in death) Last Due to (or es a consequence of) 60 980 23b. Did tobacco uas contributs to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. detached 9 Š 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. py 8 24b. Were eutopsy findings evailable prior to completion of causa of death? 24e. Wes en eutopsy performed? Completed 1 ☐ Yes 2/2 No 1 □ Yes 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 this 27. Manner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred Certification: I or Attending Patter death. Affer 1 Neturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 6 Could not be 28e. Pleca of Injury - At home, ferm, streat, factory, offica building, etc. (Specify) 4 ☐ Homicide To the Hospital o within 24 hours at To the Funeral D 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and menner as steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) Medical 29a Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of a 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JR M.D. 505 IDLEWILD AVE., EASTON, MD 21601 WILLIAM H. WOOD. 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture

DHMH 16 Rev 6/95

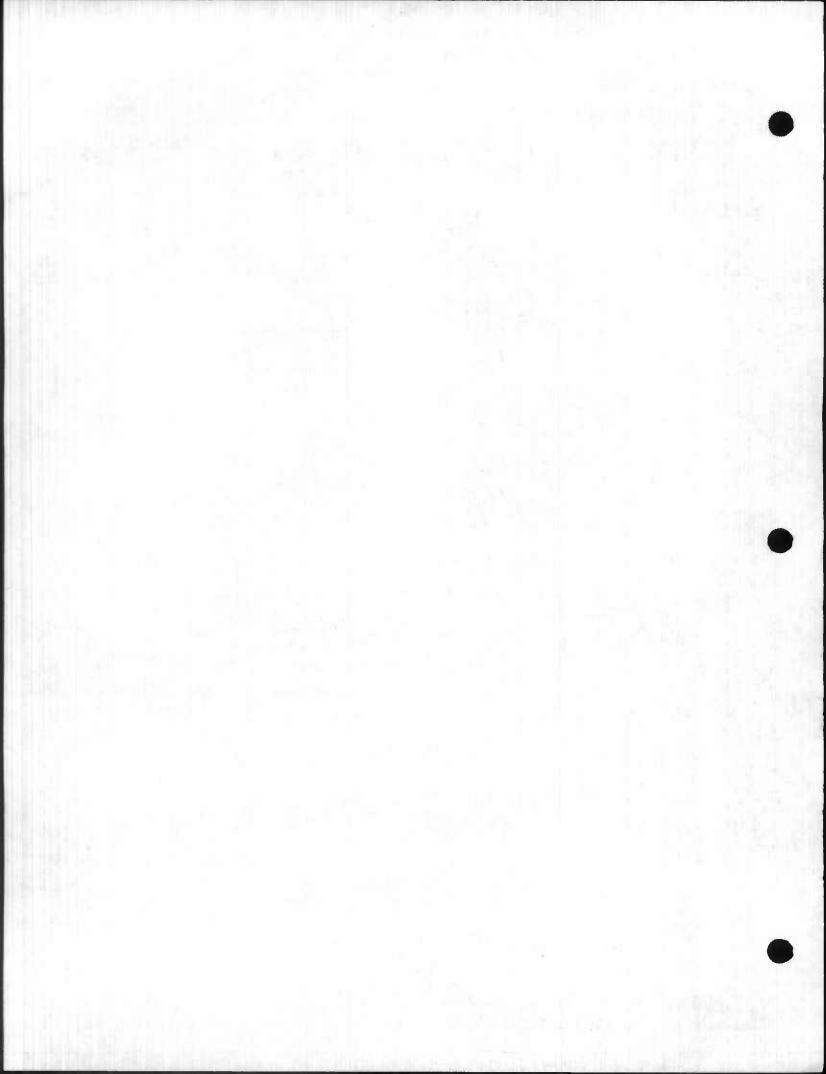
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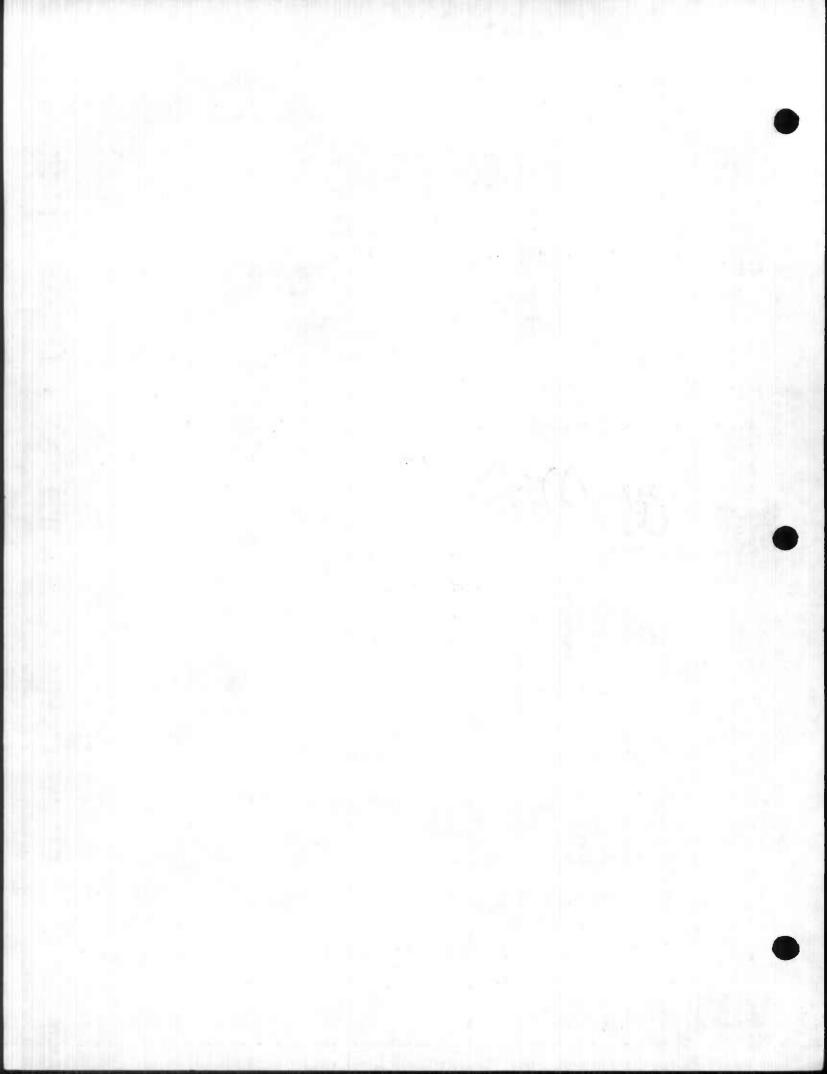


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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Пеу Month Year **Physician** Victor Thang Cao Truong 28, 2000 October 5:54 AM /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Holy Cross Hospital Montgomery H Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 150 M 2□ F Yrs. 219-41-9813 52 Director May 18, 1948 Vietnam Usuel Residence of Decedent the Maryland 10e State 10b. County 10c. City, Town or Location 10d Inside City Limits Worls ! than "natural", or items 23a or 28a-f ahov the Macical Examiner must be notified at Maryland Montgomery Silver Spring 1 ☐ Yes 2K No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 3615 Peartree Court, # 24 20906 United States Funeral death 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Evar in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after Yes 2 No 1 ☐ Never Merried 2 ☒ Married 21215-0020 1 Yes 2 No Specify à Specify: 3 ☐ Widowed 4 ☐ Divorced Asian Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elamentary/Secondary (0-12) College (1-4or 5+) Maintenance Engineer . Peges 1 and 2 should be filed w tment of Health and Mental Hygier tant: If item 27 is marked other th lury or other treumatic event, the Apartment Complex Baltimore, Maryland 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Father's Neme (First, Middle, Last) Van Huan Truong Thi Ngoc Thai 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) 3615 Peartree Court, #24, Silver Spring, MD 20906 Dinh Thuy Thu/ Wife 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Spermit. Pege Department or Important: If it any injury or o Nov. 1, 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removel Irom State 4 ☐ Donetion 5 ☐ Other (Specify) Montgomery Crematorium, Inc. 2000 Bethesda, Maryland 21. Signeture of Funerel Services Com-22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 M00689 se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** /Medical Immediate Cause (Finel diseasa or condition resulting in deeth) Under 24 hrs Respiratory Failure Examiner Due to (or as a consequence of): Examiner Metastatic Lung Cancer 15 months The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or trijury that initieted events resulting in death) Last Due to (or as a consequence of): Brain Metastasis Box 68760, 15 months Physician/Medicai the Due to (or es a consequence of): USB BS signed by the et d be deteched fo 23b. Did tobacco use contribute to the cause of death? P.O. Pert It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ₺ Unknown 1 ☐ Yaa 2 ☐ No Division of Vital Records, Completed by 24b. Were autopsy lindings available prior to 24a. Wes an autopsy performed? completion of cause of death? page 2 has 1 Yes 2₺ No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: director. 25. Wes casa refarred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2√ No this funeral 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After 1 Neturel 5 Pending investigation e Hospital or Attanding n 24 hours after death. Ne Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, Ierm, street, lactory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. 29e. Certifier edicai completely (Check only one) To the To the To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D50637 October 28, 2000 12 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) Shakun M. Malik, M.D. 106 Irving Street, Suite 420, Washington, DC 20010 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State acks 30 Registrar OCT ZUUU



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Dey Year October 28, 2000 **Physician** Stanley Alexander Trumbower 2:36 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not institution, give street and number) Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year 8. Dete of Birth (Mogth, Dey, Year) October II, 1930 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 10M 20 F Deys Min. 172-24-6764 70 Yrs. Director Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or flams 23s or 28s-f show t than "natural", or hams 23a or 28a-f sho the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Maryland Director Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13407 Roxbury Road 20904 United States Funeral 14. Rece - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Merital Status filed within 72 hours after 1 Never Merried 2 Married 1 Q Yes 2 No
If Yes, Give
Yeer or Dates: 1955-1957 Specify: White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Cotlege (1-4or 5+) Electrical Engineer Government 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be ind Mental Russell Trumbower Ada Alexander oges 1 and 2 aho opartment of Health and M important. If them 27 is on any Injury or oth-once. 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Silvia Trumbower / Wife 13407 Roxbury Rd. Silver Spring, MD 20904 20b. Pleca of Disposition (Name of carnetery, cremetory or other placa) 20e. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Buriet 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Everly-Fairfax Crematory 10/30/00 Fairfax, Virginia 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Fundfal Service Licensee 11800 New Hampshire Ave. Silver Spring, MD 20904 of r complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, as only one cause on each line. Approximate 23a. Part1 Enter the disease shock, or heart failure. Physician Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examine The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): and Division of Vital Records. P.O. Box 68760. attending physician Physician/Medical the Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed page 2 should 24a. Was an autopsy performed? this certificate has 1 Yes 2 No 1 ☐ Yes 2 No Physician: Be 25. Was case referred to medical 26. Piace of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No 1⊠Inpatient 2□ ER/Outpatient 3□ DOA To the Hospital or Attending Ph within 24 hours after death.

I to the Funeral Director: After th completely filled in by the funeral Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edical 29e. Certifier

State Registra

31. Date filed (Month, Day, Year) 2000

ss of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and the of certifier

300

DR. D. SINGAD CALCANT LOX 32. Registrer's Signeture

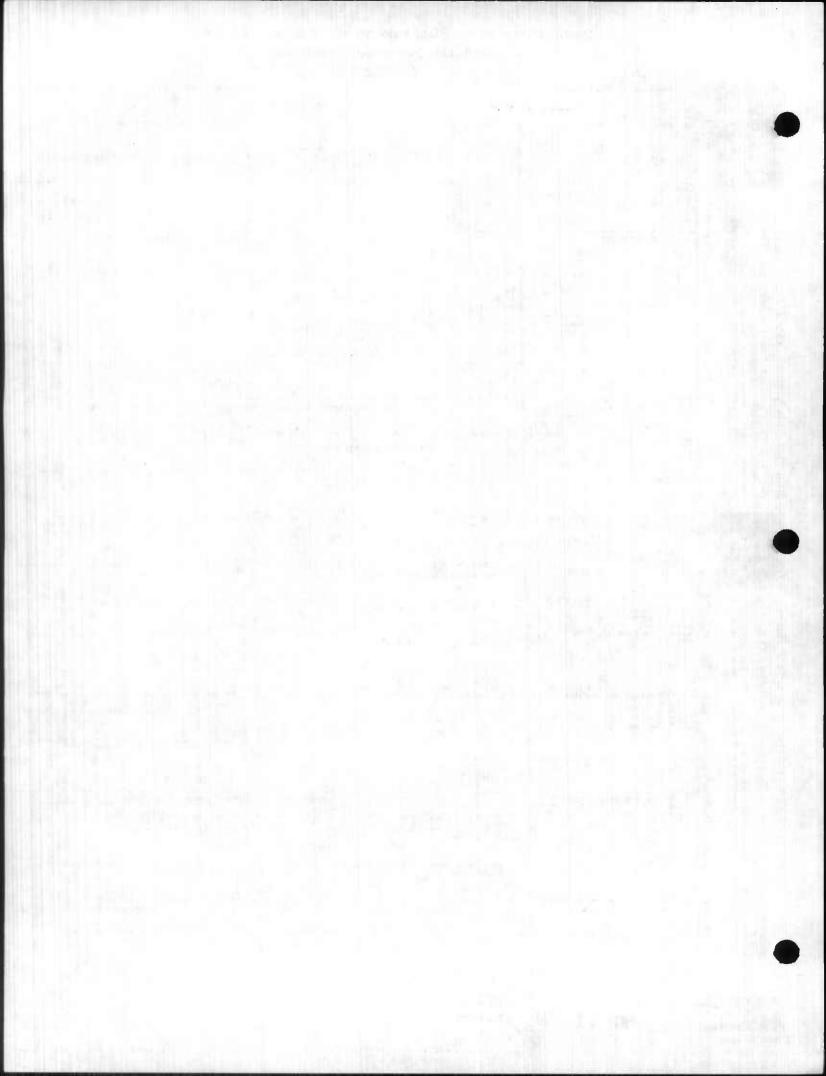
29c. License number

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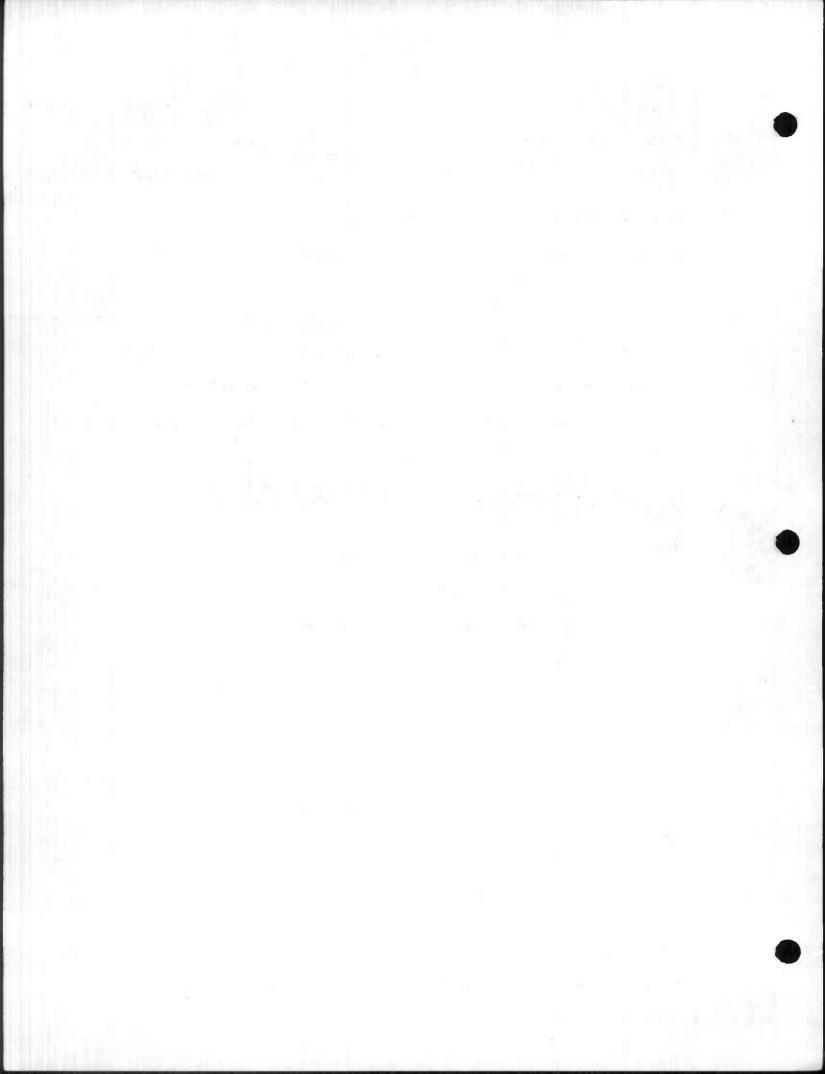
29d. Date signed (Month, Day, Year)

10-29-00

12

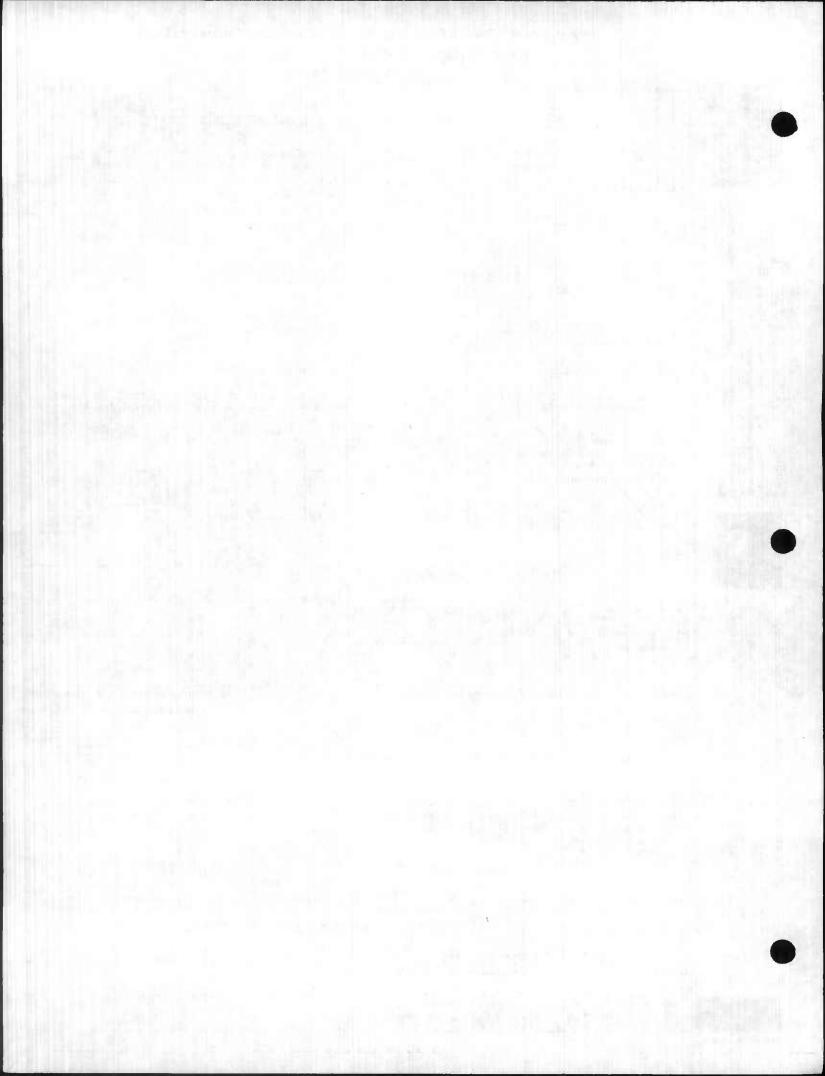


n al	1. Decedent's Name (First, Middla, La						2. Dete of De			3. Time of Deeth	
al I	Mary Ruth Thomp	son					Month	r 30, 20	Yeer	5:00 PM	
ar er	4a. Facility Neme (If not institution, giv		r)			4b. City, Town, or				3:00 PM	
1	Brooke Grove Nurs		,			Sandy S		,	tgome	3037	
			ge (In yrs. la	st birthday)	If Undar 1 Ye						
	3/9-01-12/1	□M 2☑F	84	Yrs.	Months Dey	s Hours Min		y, Year) 5, 1916	North	lece (Stete or Foreign try) n Carolina	
Ì	10e. State 10b. County		10c. City,	Town or Local	ocation 10d. Inside (
5	Maryland Montgome	rv	Sil	lver Sp	ring		1 ☐ Yas 2√☐ No				
9	10e. Street and Number					9		10g. Citizan of V	What Count	trv?	
٥	819 Richmond Avon	110					- 1			.,,	
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ě	12	Conaga (1-40)	34)		Bookke	eper		Re	tail		
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0	William L. Mackie					Eula M	ae Willi	ams			
	19a. Informent's Neme/Ralationship (ype, Print)		19b. Meiting	Address (Stre	et end Number or R	ural Routa Numbe	er, City or Town,	or Town, Steta, Zip Code)		
n 27 is	Milton Lee Thomps	on / Son		3613 T	oddsbu	rv Lane.	Olnev. M	arvland	208	32	
	20e. Method of Disposition			ce of Dispositi	ion (Neme of		Dete				
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			- OII					aldi Fu	reral	Home	
	Jano O.Tal	waity.		113	800 Nev	w Hampshi:	re Avenu	e			
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		28e. Deta of Inju	ury 2		28c. In		T'				
atio		(Month, De	oy roary	Injury							
Serunc	3 Suicide 6 Could not be determined	28a. Place of In	e, farm, street	, fectory, offic	0			er or Rural	Route Number,		
dical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	iner: On the basis of	of exeminetio	edga, deeth oo n and/or inves	ccurred et tha tigetion, in my	tlma, date end plece opinion, daath occu	a, end due to the curred et the time,	causa(s) end me dete end place,	enner es ste end due to	etad. the causa(s)	
-	29b. Signature end title of certifier				29c. Lice	nse number		29d. Date signe	d (Month, E	Dev. Year)	
	184/2000				~						
-	and one.		Settle John		7733	700		VOVEMBE	21,	2000	
				(3a) (Type, Pri	-	Howe,	1.13.				
Tacher and the state of the sta	medical cel inicatori. To be completed by rinysiciarizmedical Examiner	Usuel Residence of Decedent 10e. State 10b. County Maryland Montgome 10e. Street and Number 819 Richmond Aven 11. Marital Stetus 1 Never Married 1 Never Married 15. Dacedent's Ed (Specify only highest gre Elementery/Secondary (0-12) 12 17. Father's Neme (First, Middla, Last) William L. Mackie 19a. Informent's Neme/Ralationship (1) Milton Lee Thomps 20e. Method of Disposition 1 Regural 2 Cramation 3 4 Donetion 5 Other (Specify) 1. Street and Number 21. A Donetion 5 Other (Specify) Immediate Ceuse (Finel disease, or compand the property of the pro	Usuel Residence of Decedent 10e. State 10b. County Maryland Montgomery 10e. Street and Number 819 Richmond Avenue 11. Marital Stetus 1	Usuel Residence of Decedent Do. State	Usuel Residence of Decedent 10b. County 10c. City, Town or Local Maryland Montgomery 10c. City, Town or Local Maryland 10c. City, Tow	Usual Residence of Decedent 10e. City, Town or Location Maryl and Montgomery 10f. Zip Code 10e. Street and Number 10f. Zip Code 10f. Zip Code 11f. Martial Stetus 11f. Never Married 2 Married 12 Wee Decedent Ever in U.S. 13. Was Decedent 17fes, Specify 17fes, Spec	Usual Residence of Decedent 10c. City, Town or Location 10c. City, Town or Location 10c. Silver Spring 10c. Spring 10c. Spring 10c. Spring 1	Usual Residence of Decedent 10b. County 10b. City, Town or Location 10b. County 10b. City, Town or Location 10b. County 10b. City, Town or Location 10b. County 10b. County 10b. City, Town or Location 10b. County 10b.	Libert Residence of Decodert 100. County 100. City, Town or location Silver Spring 100. Extended Number 100. Extended Number	Use of Residence of Decederal 10c. City, Town or Location 10c. State 10c. City, Town or Location 10c. State 10c. City, Town or Location 10c. State 10c. City, Town or Location 10c. City, Town or Loca	



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3 6 2 5 9

	Certificate of Death	R	eg. No.									
Physician	Decedent's Name (First, Middle, Last)	2. Date of Deat Month		3. Time of Death								
Physician /Medical Examiner	Dorothy Iris Thompson 4a Facility Name (If not institution, give street and number) 4b. City, Town, or L	October	25, 2000 4c. County of De	9:26am								
Funeral Director		(Month, Dey,	Year)	ery intholace (State or Foreign Dountry) maica								
2	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits								
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th with the Ma the notifies at be notifies at Director	109. Street and Number 101. Zip Code 109 Sheridan Avenue 20912	10g. Citizen of What Country?										
72 hours after death with the Maryla natural, or items 23s or 23s-1 shoulds! Examiner must be notified at sted by Funeral Director.	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No H Yes, Sive Year or Dates: 1 Yes 2 No Specify:	pecity Yas or No- Ricen, etc.)	USA 14. Race - American Indian, Black, White, atc. Specify:									
ypiene ypiene ypiene Y, the Medical I Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	sing	16b. Kind of Busines	ite s/Industry								
A the	4 Analyst		U.S. Navy	7								
B star	17. Father's Name (First, Middle, Last) 18. Mother's Nam	e (First, Middle, I	Meiden Sumame)									
s marks sumarks numarks	Joseph Edley Thompson Georgian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rule)		eline Hari City or Town, State									
Pages 1 and 2 nent of Health a nrt. If Itsen 27 is any or other tree	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Place of Disposition (Name of cemetery, cremetory or other place)	Date	ark, Mary 1 a 20c. Location - City of	or Town, State								
permit. Pa Departmen Important any injury anse	Spring Grove Cemetery 11/2/00 Medina, 21. Signature of Funeral Service License Spring Grove Cemetery 12. Name and Address of Facility Francis J. Collins Funeral Home, I											
Physician /Medical	23a. Part1. Enter the disease, or complications that ceuse of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each whe. Immediate Cause (Final disease or condition Sepsis											
Examiner	disease or condition a. Sepsis resulting in death) Due to (or es a consequence of):											
nsit miner												
eath certificate be executed attending physician and for use as the buriel-transit clan/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Severe Anemia Dua to (or as a consequence of): Old CVA/Stroke											
at the death cert if by the attendin efeched for use Physician/N	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f.	23b. Did to	bacco use contribu	ite to the cause of death								
that the red by the detech		1 🗆 Y	23b. Did tobacco use contribute to to									
The law requires that the death cercate has been signed by the attendin, page 2 should be deteched for use Completed by Physician/N		24a. Was a perform		b. Were eutopsy findings available prior to completion of causa of death?								
		1 🗆 Yı	as 2 😡 No	1 ☐ Yes 2 ☑ No								
Physician: The la ribls certificate has aral director, page 2 ri. To Be Comp	examiner? (Magnital:	th (Check only on	ence 6 Other (Si									
Attanding Physician: or death. ector: After this certific by the funeral director, lification: To Be (1 Yes 2 No		ow injury occurred	овспу)								
X = = -	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)	treet and Number or n, State)	Rural Route Number,									
n 24 hound in 24 h	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occur and manner stated.	rred at the time, d	ate and place, and o	ue to the cause(s)								
To the Com	29b. Signatury and title of certifier 29c. Licansa number	2	9d. Data signed (Mo	nın, Day, Year)								
12	30. Name and address of person who completed cause of death (Julius 23a) (Type, Print)		October 26	2000								
State Registrar	Samuel L. Deshay, M.D. 7610 Carroll Avenue #320 Tale 31. Date filed (Month, Day, Year) OCT 80 2000 April 1	coma Parl	k, Marylar	nd 20912-631								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day **Physician** Bruce Linville Taylor, Jr. 24, October 2000 3:45 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 27, 1910 If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 10XM 2□ F Hours 90 Washington, D.C. 578-54-7028 Director Uaual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inaide City Limits r than "natural", or items 23s or 28s-f show the Medical Exeminer must be notified at 1 Yes 2 No Directo Maryland Anne Arundel Edgewater 2 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1035 Taylorville Lane 21037 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 1 No If Yes, Giva Yaar or Datas: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yas or No-It Yas, specify Cuban, Mexicen, Puarto Rican, etc.) Biack, White, etc. hours after 1 ☐ Navar Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yea 2 No Specify: White Specify: by 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry P. 2 should be filed within and Mental Hygiens. College (1-4or 5+) Elementary/Secondery (0-12) Periodontist Private Practice 5+ 18. Mother's Name (First, Middle, Meiden Surname) 17. Fathar's Nama (First, Middla, Last) permit. Pages 1 and 2 should be Department of Health and Mannat. Important it farm 27 is married of any Injury or other and Be Bruce L. Taylor, Sr. Helen Sewell Child 19e. informent's Name/Relationship (Type, Print) 19b. Mailing Addreas (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Brockway Taylor/Son 7705 Glendale Road, Chevy Chase, Maryland 20815 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition October 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 28, 2000 Suitland, Maryland 22 Nama and Address of Facility
Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 21. Signature of Flury rais Service Lie SA M00846 on plt it ins that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, use on each line. 23a. Part . Enter the disease, or conshock, or heart teilure. List only Approximete Interval Between Onset and Death **Physician** immediate Cause (Final disease or condition resulting In death) /Medical Lung Cancer Examiner Due to (or as a consequence of): History Tobacco Use Examin ed by the attending physician and detached for use as the burial-transit requires that the death certificate be executed Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avants Due to (or as a consequence ot): Box 68760. Physician/Medical Dua to (or as a consequence of): resulting in death) Last P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Emphysema Records, þ 24b. Wera autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peen s aw page 2 certificate has The 1 ☐ Yas 2 XNo 1 ☐ Yes 2 ☐ No Division of Vitai Physician: 25. Was case reterred to medicel examiner? Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4□ Nursing Home 5□ Rasidence 6□Other (Specify) To 1 ☐ Yas 2 No After this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Hospital or Attending Pi
 24 hours after death.
 Funeral Director: After ti
 letely filled in by the funeral Certification: 28c. Injury at Work? 5 Pending investigation 1 XNatural 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a vithin 24 hours a completely filled Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

The best of my knowledge, deeth occurred at the time, determined in the cause(s) and menner as stated.

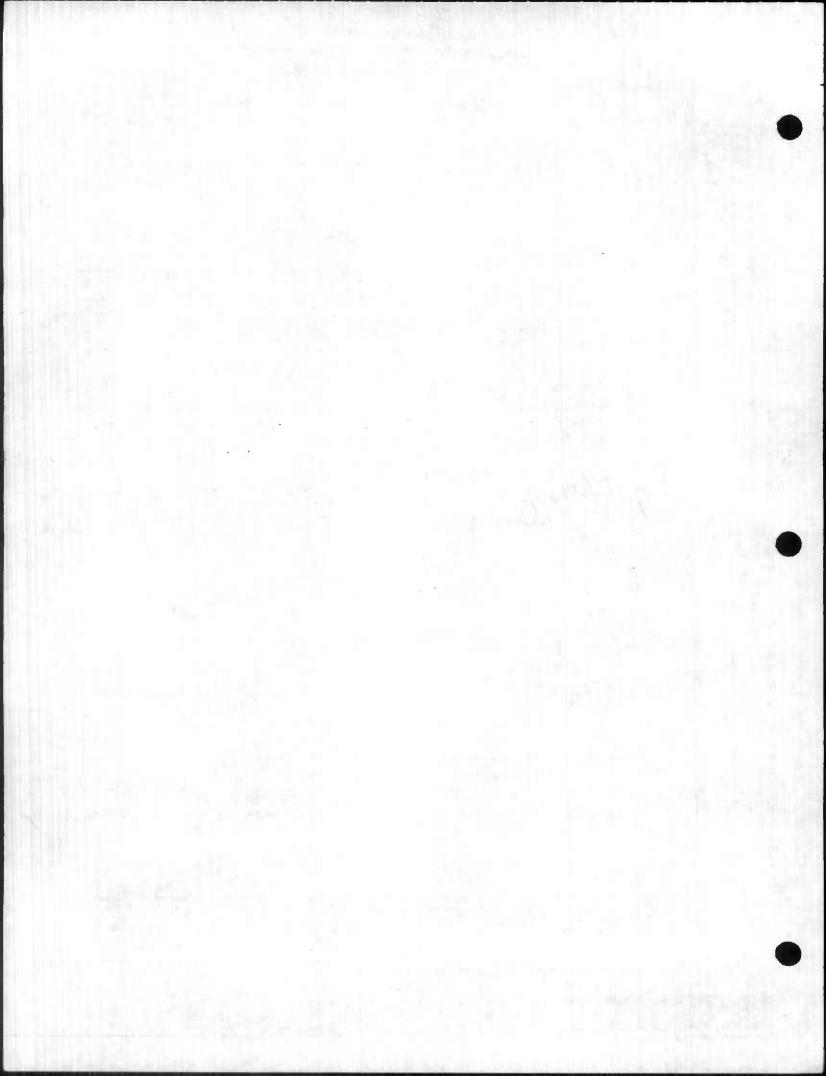
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State Registrar 31. Date filed (Month, Day, Year) 30 OCT 2000

Salata,

32. Registrar's Signature

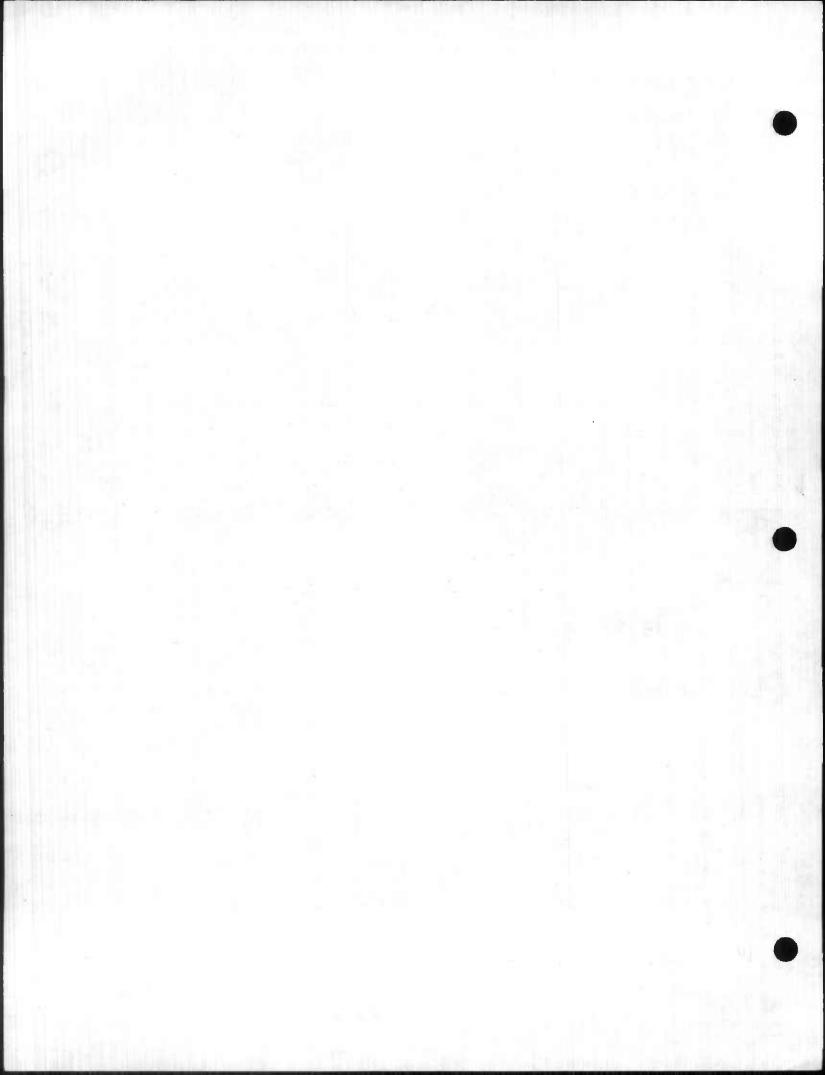
M.D., 139 Old Solomons Island Road, Annapolis, Maryland 21401



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			C	ertificate o	f Death		Reg. No.	30201		
	1. Decedent's Neme (First, Middle, L	ast)				2. Date of		3. Time of Death		
Physician	Ha S. Tat					Month Octo	ber 30, 2	000 6:10 am		
/Medical Examiner	4a Facility Name (Il not Institution, g	ive street end number)			4b. City, Town	n, or Location of D				
Cxamiller	Holy Cross Hospi	tal			Silver	Spring	Monta	omery		
Funeral			yrs. last birthda	(v) If Under 1 Yes	ar If Under 24		Birth Day, Year)	Birthplace (State or Foreign Country)		
Director	579-15-1422 Usuel Residence of Decedent	V _	Yrs.	Months Dey	ys Hours	Min. (Month, Jan	Day, Year) 16, 1958	Vietnam		
pue &	10a. State 10b. County	100	. City, Town or	Location				10d. Inside City Limits		
vith the Marylar or or 28s-f ahow the notified at	Maryland Montgom		Vheaton					1 ☐ Yes 2X No		
or 28	10e. Street and Number			10f. Zip Code	9		10g. Citizen of V	What Country?		
23a c	11404 Sherrie La	ne		20902			Vietnam			
tree death ver thems 23s	11. Marital Status	12. Was Decedent Evar	in U,S. 1:	3. Was Decedent o	Hispanic Origin	? (Specify Yes or	No- 14. Rac	e - American Indian,		
- 09	1 ☐ Never Merried 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	Armed Forcas? 1 Yes 2 ANo If Yas, Giva Yaar or Detas:	3.0	1 Yes 2 N		rueno racan, erc.,	Specify	* White etc. White		
Adryland 21215-002 2 should be filed within 72 hours and Mental tygiene. In marked other than natural; aumatic event, the Modification To Be Completed by	15. Decedent's		16a. De	cedent's Usuel Occ	cupation	ddilaa	16b. Kind of Bu	usiness/Industry		
hin 7	(Specify only highest g	College (1-4or 5+)	life	ve kind of work dor b. DO NOT use refu	ne duning most o ired)	working				
Tribunia To	12		Bar	Tender			Hotel			
tal Hy d other	17. Fether's Neme (First, Middle, Las	it)			18. Mother's	s Neme (First, Mid	dle, Maiden Suman	na)		
ife, Maryland 212. I and 2 should be filled within fleelith and Mental bygiene. Item 27 is marked other than other traumatic event, the traumatic event ev	Toan Tat				1- 34	Tong	Tat			
Maryland d 2 should be file th and Mental Hy 7 is marked oth traumatic event To Be (19e. Informent's Neme/Reletionship	(Type, Print)	19b. Ma	ailing Address (Stre	et end Number	or Rural Route Nu	mber, City or Town,	State, Zip Code)		
≥ 5 € 7 ° °	Nga My Nguyen /	Ex-wife	114	04 Sherri	e Lane.	Wheaton	, MD 2090	2		
Baltimore, Nomit. Pages 1 and Pepaminent of Health Important: If Item 27 my Injury or other trace.	20e. Method of Disposition	20		sposition (Name of remetory or other p		Date		City or Town, State		
	1 Burial 2 Cremation 3 4 Donetion 5 Other (Spec	Tremoval from Stele		litan Cre		11/2/0	0 Alexand	ria VA		
Baltimo	21. Signeture of Funeral Service Lice	··	-	22. Neme and Add		111/2/0	o niekana	IId , vn		
Physician Neura Examiner	23a. Pert1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Finel disease or condition rasulting in death)	a Liver Fai	lure	enter the mode of d	ersity B	LVC , W, ordiac or respirator	Silver S y arrest,	Approximete Interval Between Onset end Death		
<u> </u>			to (or es a cons					about		
nsit nin	Contract of the second	Metastati			al Cance	r		about 2 years		
A.O. BOX 06/00, at the death certificate be executed tby the attending physician and etached for use as the burial-transit. Physician/Medical Examiner	Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last	C	o (or es a cons							
death cert death cert e attendin ed for use sician/M						1				
ad by the detached	Part II. Other algnificant conditions	contributing to death but not	resulting in the	underlying cause	given in Pert I.			ntribute to the cause of death?		
	Tuberculosis					1	□ Yes 2 □ No	3 ☐ Probably 4 🖄 Unknow		
The law requires that the law requires that the page 2 should be deteched.	Anemia					24a. V	/as an autopsy erformed?	24b. Were autopsy findings available prior to completion of cause of death?		
The law the law ate has b page 2 s										
= = = = 0							☐ Yes 2X No	1 ☐ Yes 2 No		
VICAL SICIAN: The contilicate director, pa	25. Was case referred to medical examiner?	Hospitel: xx		1	Other:	Deeth (Check or				
T die by	1 Yes 2 No	1 W Inpatient	2 ER/Outpat	ION JU DON	4LI NUIS		lesidence 6 Oth			
2 2 2 E	27. Manner of Death 1 ②Netural 5 □ Pending 2 □ Accident investigeti		28b. Time Injury	y V	Vork?		be how injury occur			
of or Attending a ster death. Of in by the first of the	3 Suicide 6 Could not 4 Homicide determine	28e. Plece of Injury - / building, etc. (Sp	At home, ferm, ecify)	street, fectory, offic	08	28f. Location City or	ocation (Street and Number or Rural Route Number ity or Town, Stete)			
To the Hospital or a within 24 hours after To the Funeral Dire completaly filled in Medical Certif	29e. Certifier 1 Certifying F (Check only one)	hysician: To the best of my miner: On the basis of exam end mannar stated.	knowledge, de ninetion end/or	eth occurred et the investigation, in m	time, date and y opinion, deeth	place, and due to occurred at the tir	the cause(s) and manne, date end place,	anner as stated. and due to the cause(s)		
within To the Comp	29b. Signeture end title certifier	1		29c. Lice	ense number		29d. Date signe	d (Month, Day, Year)		
10	1 /	1 00		D 3	35006		Octobor	30 2000		
to	Name and eddress of person who	completed cause of death	(Item 23a) (Tim		35996		Uctober	30, 2000		
	Linda Burrell, MI				ita /100	\$41mam \$	nring MD			
State	31. Data filed (Month, Dey, Year)	2730 Univer		Ivu., Sul	LLE 400	officer 2	bring, mm			
State Registrar		000 preve		port	2					



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Death

Physician /Medical **Examiner**

Funeral Director

Nema 23a or 28a-f show the Medical Examiner must be notified at death filed within 72 hours after 8 natural'

Pages 1 and 2 should be nent of Health and Mental ant: If from 27 is marked o permit. Pages 1 and 2: Department of Health as Important: If Item 27 Is any injury or other trace

Maryland 21215-0020

Baltimore,

Box 68760.

P.0.

Division of Vital Records,

Physician /Medical Examiner

The law requires that the death certificate be executed use as the burial-transit or Attending Physician:

Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Currency Dealer 12 17. Fathar's Neme (First, Middle, Last) Norman Carlisle Thompson Mary Louise Ahalt 19a. Informant's Neme/Reletionship (Type, Print) Norman C. Thompson, Father 20b. Place of Disposition (Name of cemetery, cremetery or other place)
St. Mark's Cemetery 20e. Method of Disposition Date XXBurial 2 Cremetion 3 Removel from State 10/15/00 4 □ Donation 5/□ Other (Specify) 21. Signature of Furieral Sarvice Licensea

Williams, Owner

Bara A. Williams, Owner 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) one ho Due to (or es e consequenca of) Physician/Medical Examiner cuhamenio Sequentielly list conditions, if any, leeding to immadiate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Lest Due to (or as e consequence of): Wold 7756-Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. þ after death.

Director: After this certificete has been sist in by the funeral director, page 2 should I Be Completed 1 Yas 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA 27 No 1 Yes Medical Certification: To 27. Menner of Death 5 Pending Investigation Neturel Injury 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) rd ni belli 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled 29a Certifier 29c. License number 29b. Signature end title of certifier 30. Nema end address of person who completed cause of deeth (Item 23a) (Type, Print)

Luuses

32. Registrar's Signature

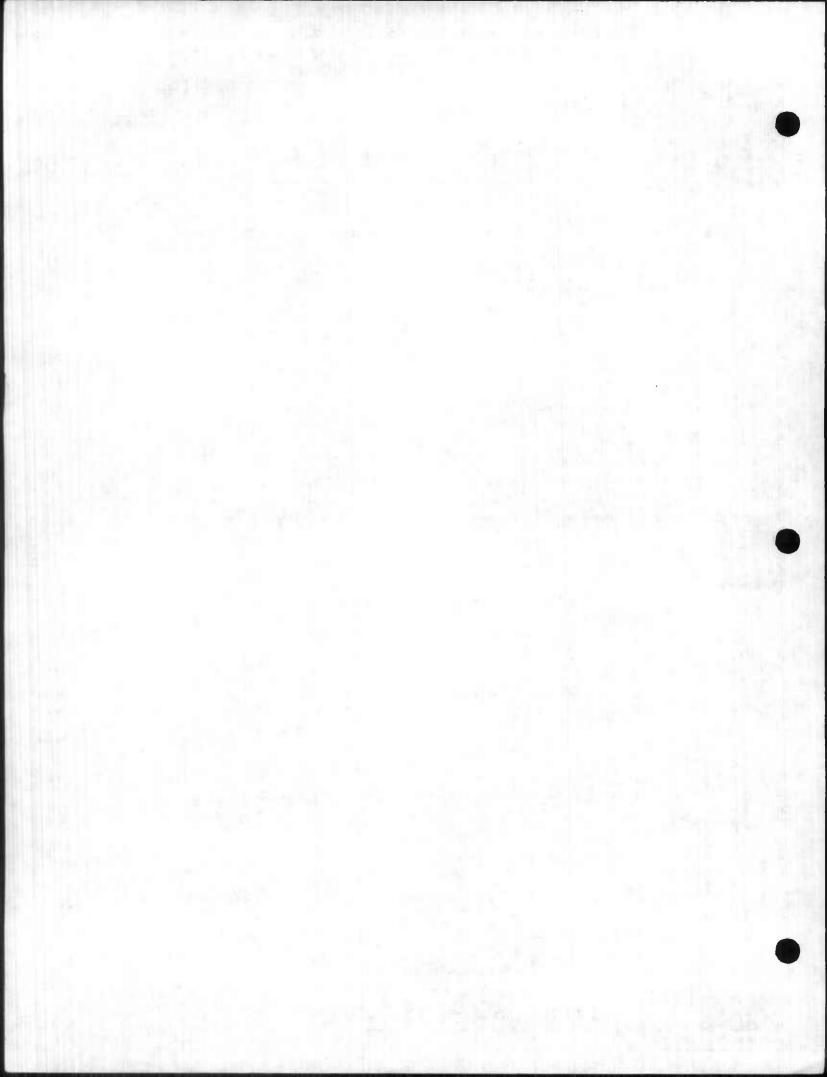
9

31. Data filed (Month Pay, Year) 2000

Day 12, Ronald Lee Thompson October 2000 4:53 P.M. 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick
H Under 1 Year H Under 24 Hrs. Frederick 5. Social Sacurity Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 1**X** M 2□ F Months Deys Hours Min. 214-54-0443 52 Yrs Frederick MD Usual Residence of Decedent 10a. Steta 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 20 No Frederick Funeral Director Knoxville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4121 Weston Drive 21758 USA 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 1 ☐ Yes 2 🖔 No If Yes, Give 1 Never Merried 2 Married 1 ☐ Yes 2 K No Specify: White Specify: by 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes 16b. Kind of Business/Industry Self-Employed 18. Mother's Neme (First, Middle, Meiden Sumame) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 4121 Weston Drive, Knoxville, MD 20c. Location - City or Town, Stata Petersville, MD John T. Williams Funeral Home 100 Petersville Road, Brunswick, MD 21716 Approximate Intervel Between Onsat and Death 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings aveileble prior to completion of cause of death? 24e. Was en autopsy performed? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 281. Location (Street end Number or Rurel Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) end manner es stated.

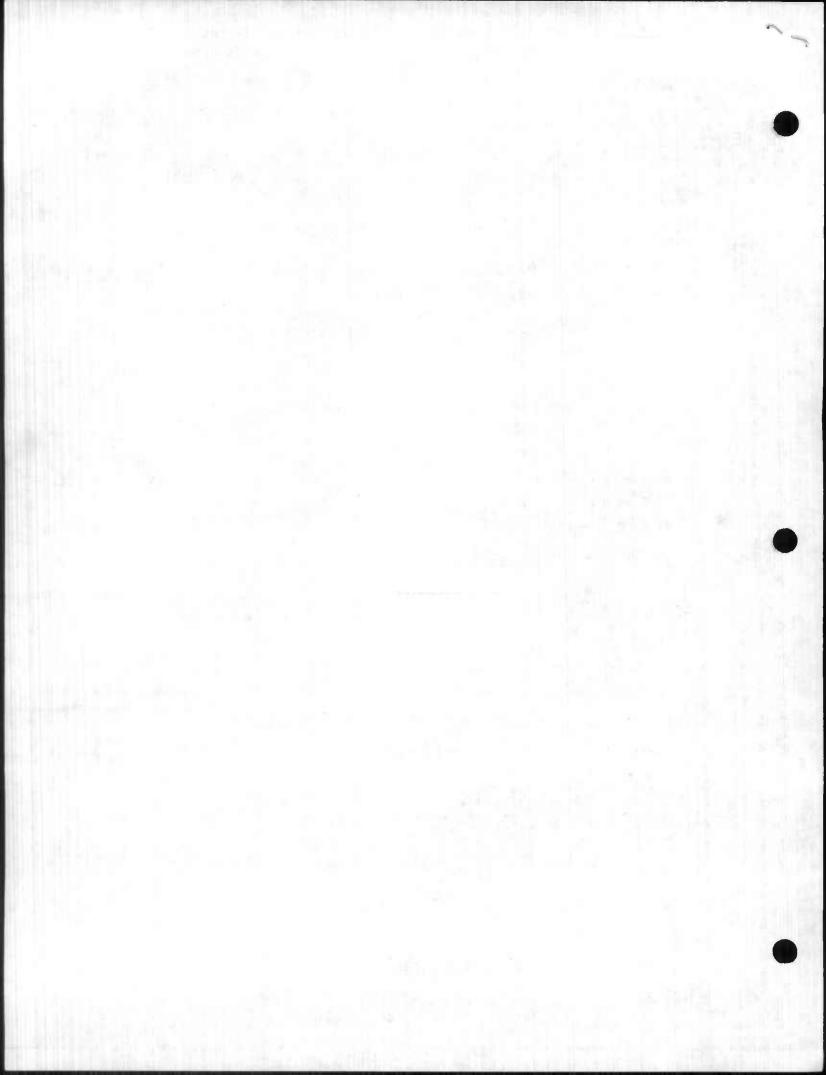
Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end pleca, and due to the cause(s) end menner stated.

State Registrar 51-



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	nended item# 1. Decedent's Name (First	23 per st, Middle, Lasi	docto:	10/18	1 2000.			P	2. Date of D		V	3. Time of Dea
an cal	Annie Vi	rginia	Louis	e Twenty	r				Month	ber 13.	2000	7:35
ner	4a Facility Name (II not i	1111						b. City, Town, o Frederi	Location of Des	100	y of Death erick	
	Frederick M 5. Social Security Number			1tal 7. Age (In yrs.	last hirthday)	If Under 1		If Under 24 H	s I a Data of B	Cetto		
	219-20-4762 Usual Residence of Dece	10	М 2 Г F	87	Yrs.	Months	Days	Hours Mi	02-18-	Day, Year)	Vir	plece (Stete or Fo ntry) ginia
		. County		10c. Cit	y, Town or Lo	cation						10d. Inside City L
tor	MD Fr	ederic	K	Fi	ederic	k						Yes 2
Director	10e. Street and Number	ъ.				10f. Zip (10g. Citizen of		
	812 Shawnee	Drive	40 144 0		0 100	217		in-nal- Origina	(0it-V	United	11144	es can Indian,
23	11. Marital Status 1 Never Married 2 3 Widowed 4 1		Armed F	2 ZNO	11	Yes, speci	ify Cuba -	Specify:	(Specify Yes or Nerto Rican, etc.)	Bla	ack, White,	etc.
Completed	15. [Decedent's Edu	cation		16a. Deced	ent's Usual	Occup	ation		16b. Kind of E	Business/In	dustry
-	(Specify on Elementary/Secondery	ly highest grad) (1-4or 5+)	life. E	OO NOT use	e retired	during most of w	orking			
	11				Sea	mstre	ess			Cloth		
90	17. Father's Name (First, Arthur E.									le, Maiden Sume	me)	
2	19a. Informant's Name/F		ma Print)		19h Mailin	o Address	(Stroot		Danner I	ber, City or Town	State 7i	n Code)
	Misti Love			ece					Myersvil		2177	
1	20a. Method of Disposition		ac m	20b. P	taca of Disposemetery, crem	sition (Nam-	e of		Date	20c. Location		
-	1 🔀 Burial 2 □ Cre 4 □ Donation 5 □ 0			State	1t. Oli	•			10-18-2	2000 Fre	ederi	ck MD
	21-Signature of Funeral		-							Funeral		
1	1 Hours	V!	X	1	16	521 Or	oss	umtown	Pike F	rederick	, MD	21702
	235 Part1. Enter the dis	ease, or comp	lications that	caused the deat		_						Approximate Interval Between
												Onset and Dea
	fmmediate Cause (Final disease or condition resulting in deeth)			PNEUMO	-	Aspir	ati	on Pneu	monia			2 WEF
	rosannig in doodin			Due to (o	r as a conseq	uenca of):						
			b	ASCIRA	1.00						-	J (7) 86
	Sequentially list condition if any, teading to immedicause. Enter Underlying Cause (Disease or Injury	ns, ate		Due to (o	r as a conseq	uerica oi).						
	that inflated events		c	Due to (o	r as a consequ	uenca of):						
	resulting in death) Last					,					i	
			d	4 114								
	Part II. Other eigniffcant	conditions co	ntributing to	seath but not res	ulting in the ur	nderlying ca	use giv	en in Part I.	23b. Di	d tobacco use c	ontribute 1	to the cause of
ruysiciativme	CERED LO.	JAICOL	AR C	DISSAJE	with	اعاد	CV	'A	10	Yee 22No	3 Pro	obably 4 Ur
2		0 110 000		1-0/20					24a Ws	as an autopsy	24b. W	/ere autopsy find
Сотрісте	DIABE-	TES:	1771	ERTENS,	سر ہ				pe	rformed?	a ¹	vailable prior to emptetion of cau death?
	Prost.			DISEAS	c				15	Yes 22No		☐Yes 2☐N
	25. Was case referred to		ER	Discus				26 Place of F	eeth (Check on)			
	examiner?	-	lospitel:	Inpatient 2	ER/Outpatien	t 3 DO	A Oth	or:		sidenca 6 🗆 Ot	ther (Speci	ify)
2	1 Yes 2 No		28a. Date	of fnjury nth, Day Year)	28b. Time of injury	28	Bc. Injur	y at k?	28d. Describ	e how injury occu	urred	
2	1 ☐ Yes 2 No 27. Manner of Death	Pending				М		Yes 2 □ No				
	1 Yes 2 No 27. Manner of Death 1 Natural 5 2 Accident	Pending investigation	(1010)				office		28f. Location	(Street and Num	nber or Rui	ral Route Numbe
	1 Yes 2 No 27. Manner of Death 1 Natural 5		28e. Plac	a of Injury - At he ling, etc. (Specif	ome, farm, sfre	set, factory,			City or 1	own, State)		
Certification: 10 Be	27. Manner of Death 1 Natural 5 C Accident 3 Suicide 6 C 4 Homicide	investigation Could not be determined Certifying Phy	28e. Plac build sician: To the	ling, etc. (Specification) be best of my kno casis of examina	v) wiedge, death	occurred a	nt the tin		ca, and due to th	own, State) e cause(s) and me, dete and place		
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** CATHERINE MAY TOMS 2000 October 0 7:50P.M. /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Reeders Memorial Home Boonsboro Washington If Under 24 Hrs. 5 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Dete of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** Deys Months Hours 1□M 2K)F Yrs. 220-38-0682 59 Director Feb. 15, 1941 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Washington Smithsburg 10e. Street and Number 10f Zip Code 10g. Citizen of Whet Country? Route 1 21783 U.S.A. Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status Wes Decedent Ever in U,S. Armed Forces? Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give 1 Yes 2 No Specify: Specify: p 3 Widowed 4 Divorced Yeer or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Seamstress London Fog Factory 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) 89 Leroy Toms Leona May Green 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) George A. Wolfe (Friend) Route 1 Smithsburg, Maryland 21783 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stata 1 ₽ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 Donation 5 □ Other (Specify) Moriah Cemetery 10/17/00 Foxville, Maryland 22 Name and Address of Facility & SON FUNERAL HOMES, P.A. 21. Signetura of F 615 EAST MAIN STREET, THURMONT, MD 21788 23e. Pert1. Enter the disease, or complications that counsel he deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear failure. List only one cause on each limit. Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel breas disease or condition resulting in death) Examiner celan Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Physician/Medicai Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1□ Yes 2No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Menner of Deeth 28d. Describe how injury occurred 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homleide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medicaf Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and menner stated. 29a. Certifier Medicai (Check only one) 29b. Signeture and title of certified 29c. License number 29d. Dete signed (Month, Day, Year) D32518 10.14.00 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Keedysville, Maryland 21756 301-432-2222 100 Geeting Lane Dr. Robert Guedenet 31. Date filed (Month, Dey, Year) 32. Registray's Signature State Registrar

DHMH 16 Rev 6/95

r 28a-f show notified at

23a or

If from 27 is

Pages

The law requires that the death certificate be executed

Box 68760,

P.0.

Division of Vital Records,

or Attending Physician:

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the USB-BS

signed by the

page 2

certificate

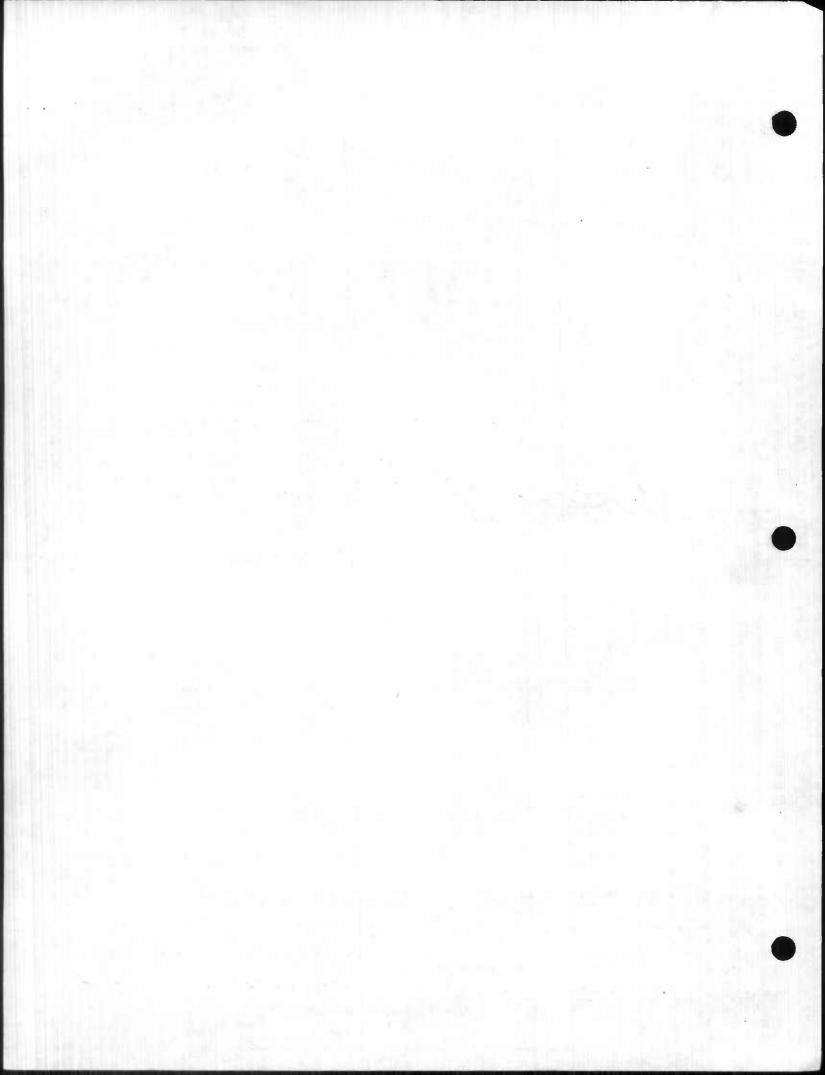
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After t

To the Hospital or Attendir within 24 hours after death. To the Funeral Director: At

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altimore,



Please Type or Print in Biack indelible ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middla, Last) 3. Time of Death Kazuko Niwa 2000 Thompson October 29 10:01 PM

Physician
/Medical
Examiner

Medical Certification: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di

Examiner	4a Facility Name (If not institution, g	iva street and number)			4b. City, Town, or	Location of Death	4c. County			
	Frederick Me	morial Hospita	1		Frede			erick		
Funeral Director		Sex 7. Age (In yrs 1		If Under 1 Yes Months Day			8, 1934	9. Birthplace (Stata or Foreign Country) Japan		
Varyand Fahow Mari	Usual Residence of Decedent 10a. State 10b. County Maryland Freder		ity, Town or Loca ederick	ation				10d. fnside City Limits 1 ☐ Yes 2 No		
with the Marylar 3e or 28a4 show it be notified at	OULD WITITIO DO	ne		10f. Zip Code 2170	1	10g. Citizen of What Country U.S.A.				
020 urs after death et, or flems 23 Examiner munt		12. Was Decedent Ever in I Armed Forces? 1 ☐ Yes ZONo If Yes, Give Year or Dates:	WY	as Decedent of Yes, specify Cu	Hispanic Origin? (uban, Mexican, Pue o Specify:	Specify Yes or No- rto Rican, etc.)	Blac	a - American Indian, k, White, etc. : Japanese		
72 ho final fical	15. Decedent's 8	Education rade completed)	16a. Deceder	ecedent's Usual Occupation liva kind of work dona during most of		orkina	16b. Kind of Bu	usiness/Industry		
21215-0020 ad within 72 hours at yopens, at their "natural", or at the Medical Exem Commission by 8	Etementary/Secondery (0-12)	College (1-4or 5+)	lifa. DC	o NOT usa rati emaker	red)		Home			
yland vid be file Wental Hys when a Hys rice avent.	17. Father's Name (First, Middle, Las		wa		18. Molher's Ne	eme (First, Middla, M	Maidan Sumam Suzuk			
Mary anh and N 27 is man	19a. Informant's Name/Relationship Karen Y. Thompso					d., Germa		Stata, Zip Coda) Md. 20876		
altimore, mit. Pages 1 a partment of He portant: If Hem y Injury or othe	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donetlon 5 Other (Special Control of Control	Removal from State	Place of Disposit cemetery, crema Lthsburg C	atory or other p	v, Nov. 2, 2			City or Town, Stata burg, Maryland		
Baft permit. Departitions any injury ang injury	21. Signature of Funeral Service Lice	1 A				ford P.A. St., Frede				
Physician	23a. Part1. Enter the disease, or con shock, or heart feilure. List onl	mplications that caused the dee y one ceuse on each line.	th. Do not enter	the mode of d	ying, such as cardi	ac or respiratory arre	est,	Approximete tnterval Between Onset and Death		
/Medical Examiner	Immediate Cause (Final diseesa or condition resulting in death)	a ACUTE		ARDINC	- INFA	Retion		30 MINUTES		
asecuted n and iel-transit			b. ARTERIOSCUEROTIC CARDIO-VASCULAR DISEASE							
U . 6 -	Couse. Lines Originitying	Due to (
P.O. Box 68760, at the death certificate be secured by the attending physician and stached for use as the burial-transi Physician/Medical Exami	Cause Consease of Injury Inat initiated events resulting in death) Last	Due to (or as a conseque	ence of):						
death certificate attending place as the death certificate as the death		0.								
£ X 0 .		contributing to death but not re	sulting in the und	derlying cause	given in Pert I.			ntribute to the causs of death? 3 Probably 4 Minknown		
of Vital Records, Physician: The law requires the this certificate has been signeral director, page 2 should be completed by						24a. Was a perform		24b. Were autopsy findings available prior to completion of cause of death?		
The la page of						108Y	es 2 No	1 Ves 2□ No		
Vital Indicate certificate rector, pag	25 Was case referred to medical					eath (Check only on	a)			
Physic critis con rathing critical direction.	1 ☐ Yes 2 № No	1	ER/Outpatient	3LI DON		Home 5 ☐ Reside				
	27. Menner of Death 1 Anatural 5 Pending 2 Accident Investigati		28b. Time of Injury	28c. In V M 1	jury at Vork? ☐ Yes 2 ☐ No	28d. Describe ho	ow Injury occur	red		
Division or Attending after death. Director: After d in by the fune	3 Suicide 6 Could not determine	28e. Place of Injury - At the building, etc. (Special Control of the building) and the building of the buildin		et, factory, office	Э	28f. Location (Si City or Town	reet and Numb n, State)	per or Rurel Route Number,		

State Registrar

29e. Certifier

29b. Signature and title of cartified

GENLGE 1. SMITH
31. Date filed (Month, Day, Year)

DHMH 16 Rsv 6/95

ORIGINAL

VICE. PRES 32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

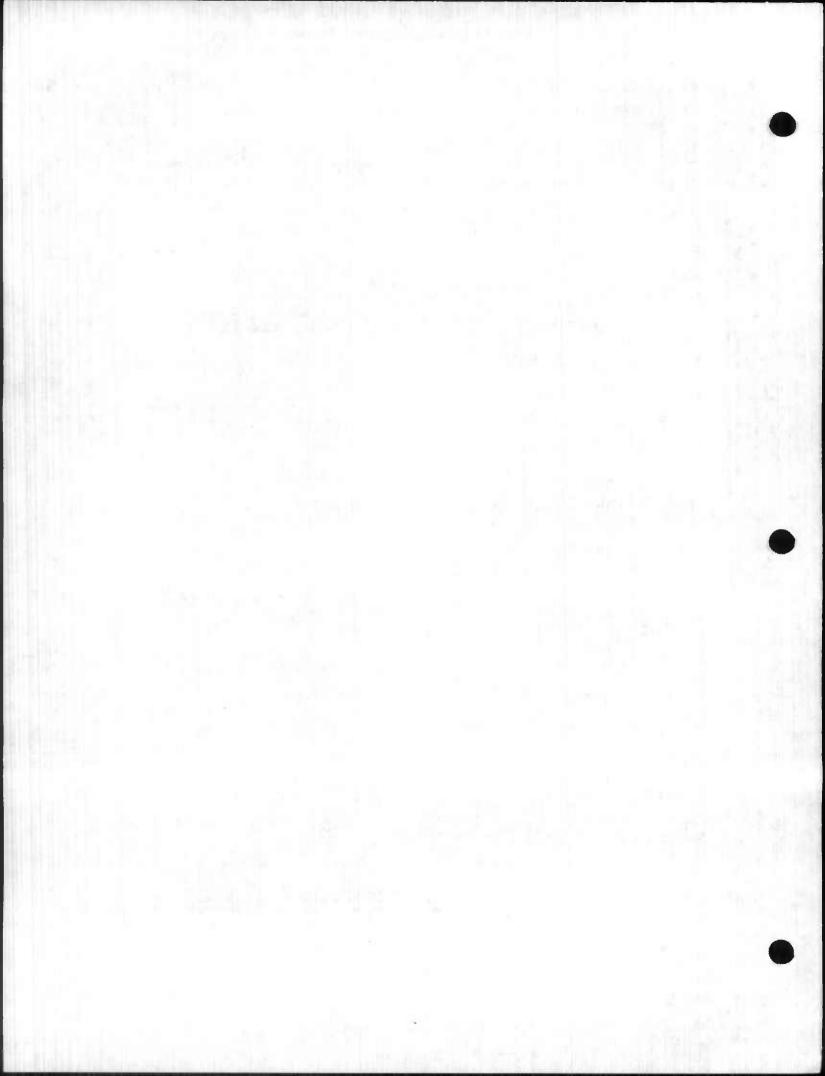
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and dua to the cause(s) and manner stated.

FREDERICK

29d. Date signed (Month, Day, Year)

2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [Certificate of Death 2. Date of Death 1. Decedent's Nama (First, Middle, Last) Month, Yaar 10 **Physician** W. TAYLOR JAMES 2000 C /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARFOR MARINER 5. Social Security Number Del HEALTH-DEL Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthdey) **Funeral** Days Hours 10XM 2□ F Months 77 March 12, 1923 Maryland 215-14-4912 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☑ No Directo Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1327 Amyclae Place 21015 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Na 2 No If Yes, Give 1943— Year or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black Š 3 ☐ Widowed 4 ☐ Divorcad 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elamantary/Secondary (0-12) College (1-4or 5+) Concrete Finisher 8 Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Joseph Johnson Jane Taylor 19b. Mailing Address (Streat end Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 1327 Amyclae Place, Bel Air, MD 21015 Sharmetta Jackson / Niece 20b. Place of Disposition (Neme of cemetery, crametory or other pleca) 20c. Location - City or Town, State 20a. Method of Disposition Data 1 X Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Spacify) James United Meth. 10/28/00 Jarrettsville, MD 22. Name and Address of Facility Lisa M. Scott Funeral Services 21. Signature of Funeral Servica Licansee Disa Scott 552 Lewis Street, Havre de Grace, MD 21078 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, auch as cardiac or respiratory arrest, ahook, or haart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Lung CANCER UNKADUN Examiner Dua to (or as a consequanca of): Examiner CEPERRAL VASCULAR DISEASE years Sequentially list conditions, if any, leading to immediata cause. Entar Undarlying Cause (Disease or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of) Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 5 Unknown Revendent Lasulin Di azetes by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autoosy Completed NA 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examinar? 26. Place of Daath (Check only ona) Other: Nursing Home 5 Residence 8 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA 1 Yes 2 No Certification: To 28c. Injury at Work? 27. Manner of Death 28b. Tima of 28d. Dascribe how injury occurred 28a. Date of Injury (Month, Day Year) 1X Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No NA investigation 6 Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify) 4 - Homicida JECertifying Physician: To the best of my knowledga, daath occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier edical

Records, P.O. Box 68760,

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7 is marked other than "natural", or items 23s or 28s-f shor treumstic svent, the Medical Examener must be notified at

filed within 72 hours after Hygiena.

. Pages 1 and 2 should be fill mant of Haalth and Mental Hant: If item 27 is marked oth jury or other treumetic aven

Baltimore, Maryland 21215-0020

Hospital or Attending Physician: To the Hospi within 24 hour To the Funer completaly fil

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29c. License number

29d. Data signed (Month, Dey, Year)

29b. Signature and title of certifier

Octo Bur 25, 2000

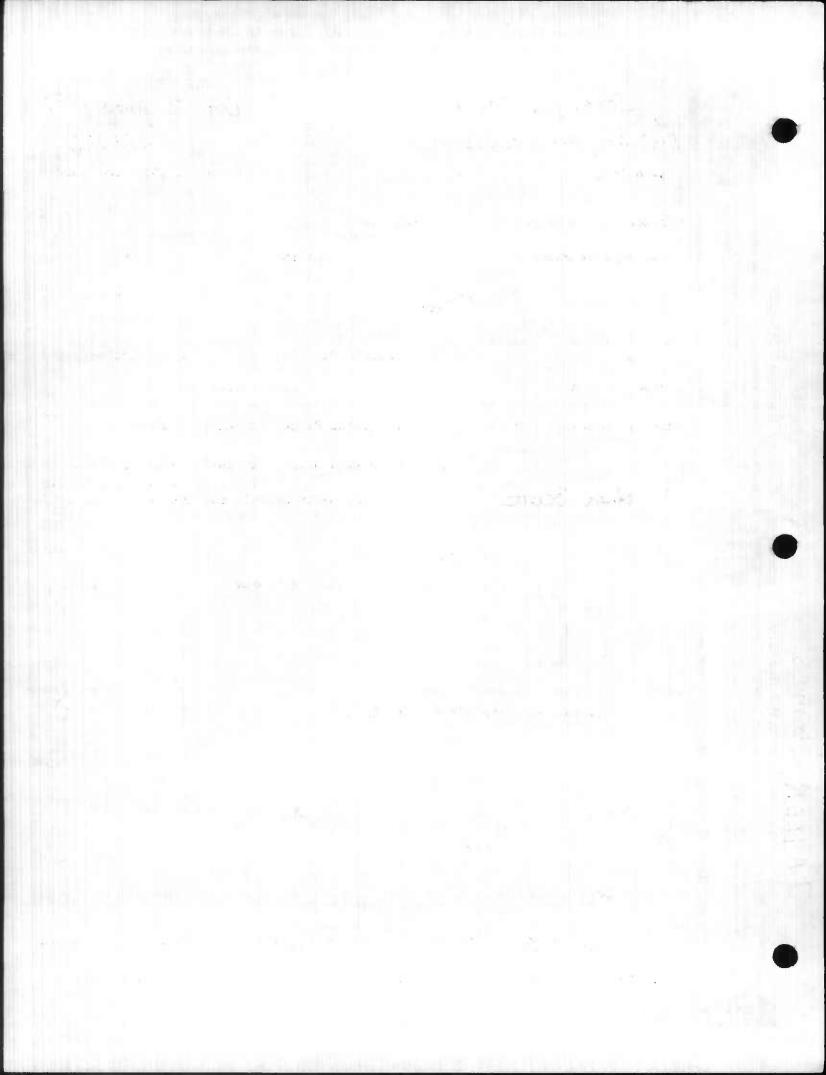
30. Name and address of person who completed cause of death (Itam 23a) (Type, Print) ALFRED SPANUS MD 6.15 W. 615 W. MACPHAIL RD BEL AIR 21014

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

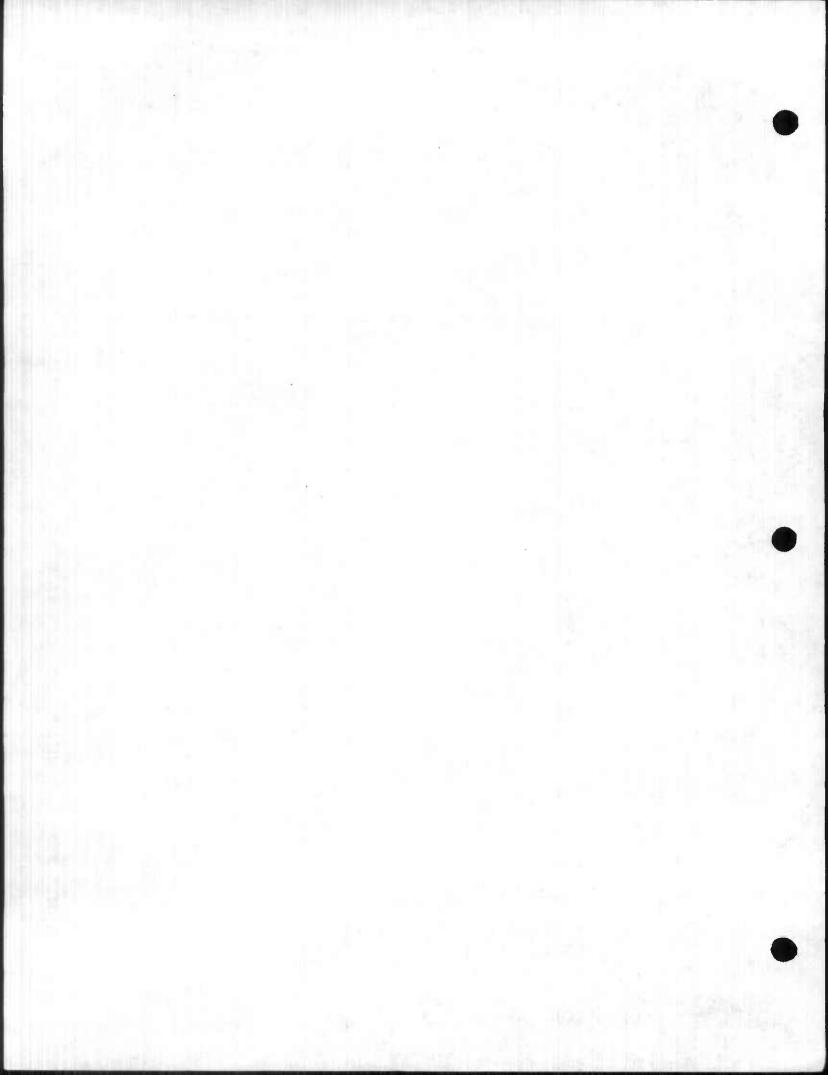
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent'e Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Hober 27, 2000 420 AILEEN JUDD VREELAND /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner etimore City General akyland If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (Stete or Foreign Country) **Funeral** 1 M 2 KF Months Days NEW YORK Director AUG 24 1928 222-18-0601 Usual Residence of Decedent the Maryland 10a. Stete 10b. County Pages 1 and 2 should be filed within 72 hours effer death with the Marylan nent of Health end Mentel Hygiene.
ant: If item 27 is marked other than "natural", or itema 23a or 28a-f ahow ury or other traumatic event, the Marical Examinar must be notified as 10c. City. Town or Location 10d. Inside City Limits 1 XYes 2 No Director TALBOT OXFORD 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 106 PLEASANT ST. 21654 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ ZÃNo If Yes, Give Year or Dates: 14. Raca · American Indian, Biack, Whita, etc. 11. Merital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yas 2 XNo Specify: Specify: WHITE þ 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Coilege (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ROGER MORRIS JUDD ETHEL CHAPMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) VIRGINIA VREELAND/DAUGHTER 2289 ACUSHNET AVE., NEW BEDFORD, MASS 02745 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State permit. Pages Depertment of Important: If it any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OXFORD CEMETERY 10-31-00 OXFORD, MD 22. Neme and Address of Facility 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrast, shock, or heart failure. List only one cause on each line. 200 S. HARRISON ST EASTON, MD 21601 Approximate Interval Between Onset end Deeth **Physician** Immediata Cause (Finet disease or condition resulting In death) /Medical neumoria Examiner Due to (or as a consequence of) Physician/Medical Examiner RUTOR Sequentially list conditions, if any, leading to immadiate ceuse. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760. Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown signed by g Vital Records. 24b. Were autopsy findings eveilable prior to Be Completed 24a. Was an autopsy performed' complation of cause of death? page . 2 PNo 1 Yes 1 Yes 2 No or Attending Physician: funeral director. 25. Was case referred to medical 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA of Medicai Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 DNatural 5 Pending after death. 1 Yes 2 No investigetion 2 Accident 6 Could not be detarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 4 Homicide filled in 24 hours a Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 24 ho To the Fune completely fi 2 Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print) General Hospital 10 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State OCT 3 0 2000 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** John 0420 011 32 EL 2 8 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montpomer Bethesda Suburban 04 8. Date of Birth (Month, Day, Nov 22, If Under 24 Hrs. If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State of Foreign **Funeral** 1X M 2□ F Months Days Hours Yrs. 16 1983 Maryland Director 216-06-9242 Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d, Inaide City Limits or flams 23s or 28s-f show 1 Yes 2 No Director Maryland Montgomery Rockville the Medical Examiner must be notifi-10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 15311 Rosecroft Road 20853 Funeral USA 12. Wes Decedent Ever in U.S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, Whita, atc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1Ñ Never Married 2□ Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within Ban Elementary/Secondary (0-12) College (1-4or 5+) Student N/A 11 17. Fether's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) 2 should be fl and Mental F Tamara Ball John Charles Vollmer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) . Pages 1 and 2 Department of Health a Important: If them 27 is any lojury or other trau once. 15311 Rosecroft Road, Rockville, MD John Charles Vollmer / Father Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata Date 1 DBurial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 10/31/00 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licansee 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901 Approximate Interval Batween Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Physician /Medical Immediate Cause (Final disease or condition resulting in death) 7600 Examiner Dua to (or as a consequence of) Be Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last as the burial-tran Due to (or as a consequence of): P.O. Box 68760, ettending physician for use as the buria Due to (or as a consequence of) detached f Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part i. 23b. Dtd tobacco use contributs to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 68 Division of Vital Records, 24b. Wara sutopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 00 s certificate has b director, page 2 s 10/28/0 2 No 1 Yes 1 ☐ Yes 2 ☐ No tuneral director, p 25. Was case reterred to medical examiner? 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Rasidenca 6 Other (Specify) Yes 2□ No Inpatient 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred Vehicl 28c. Injury at Work? 27. Manner of Death 28b. Time of s after death.

Il Director: After the of in by the funera 28a. Date of Injury (Month, Day Year) HN Injury 1 Natural 5 Pending 1 Yes 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 2311 speed investigation 22 Accident 6 Could not be detarmined 28f Location (Street and Number of City or Town, State) 3 Suicide 20 filled in by 4 Homicide mote To the Hospital o within 24 hours af To the Funeral Di completely filled is Kensin STreet Medical C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and many installand.

Registrar

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29b. Synature and title of certifier

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

30. Name and address of person who complated cause of death (Item 23a) (Type, Print)

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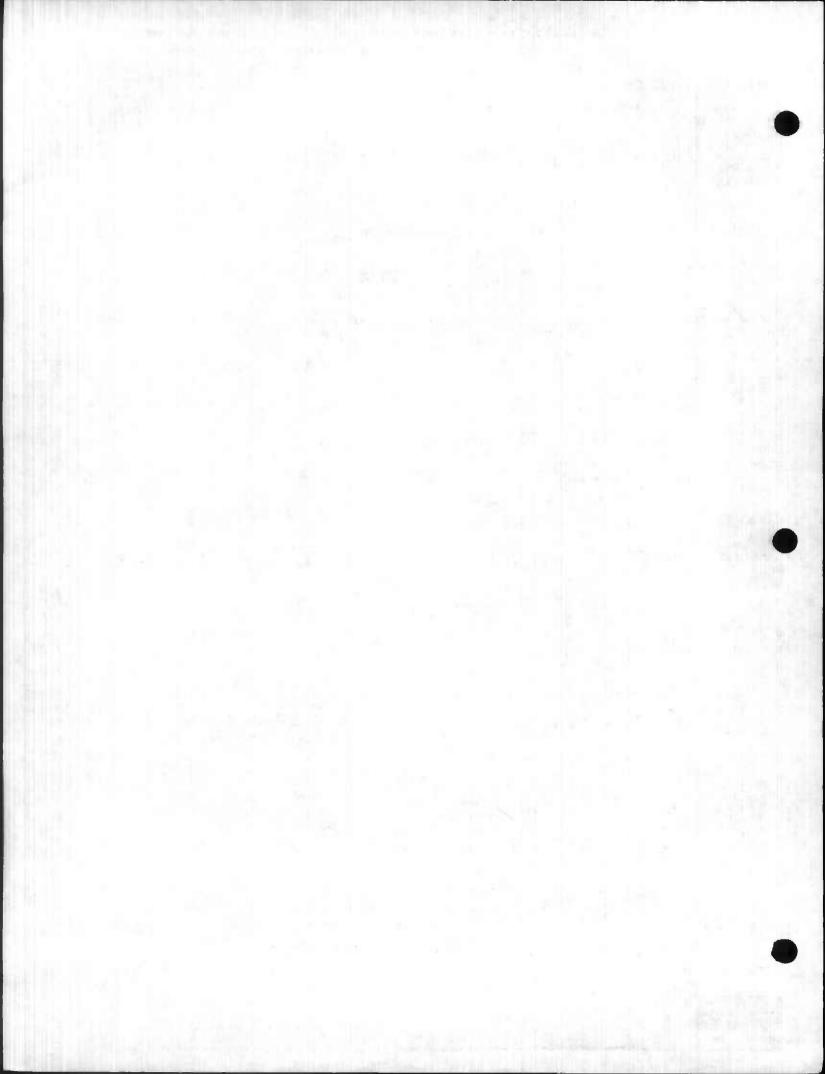
29c. License number

29d. Date signed (Month, Day, Year)

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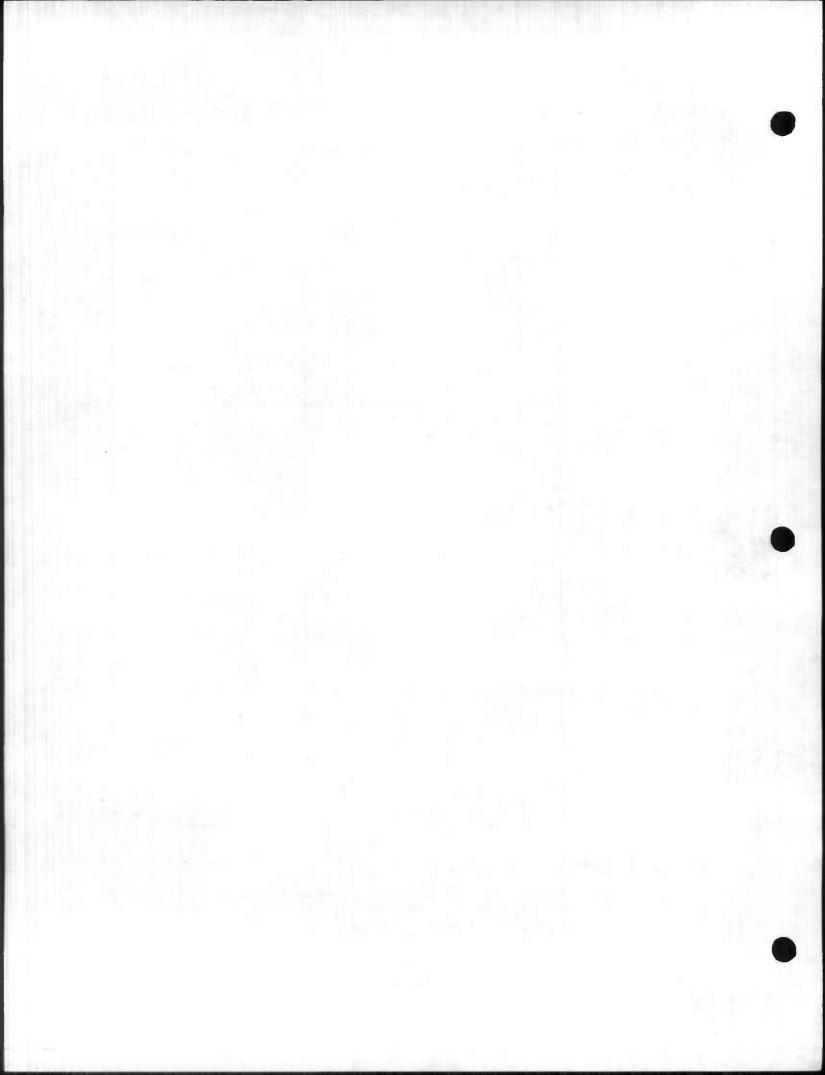


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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Eddie Valentin November 2 2000 3:00 a.m. /Medical 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 19336 Circle Gate Drive Apt 201 Germantown Montgomery H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jan 1,1987 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthpiace (State or Foreign Country) New York **Funeral** 068-72-2465 1♥M 2□F 13 Yrs. Director Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at 1 ☐ Yes 2 No MD Director Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ð Nerra 23a 19336 Circle Gate Drive Apt 201 20874 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 7 Hyglene. other then 'n Elementary/Secondary (0-12) College (1-4or 5+) Student Education 8 permit. Pages 1 and 2 ahourd be file.
Department of Health and Mental Hyp.
Important: if Item 27 is marked other any Injury or other trauments office. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eriberto Valentin Nelida Medina 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20874 19a. Informant's Neme/Reletionship (Type, Print) Nelida Medina / Mother 20b. Plece of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Nov 6, 1 Burial 2 Cremetion 3 Remove State Silver Spring, MD Gate Of Heaven Cemetery 5 Other (Specify) 2000 22. Name end Address of Facility DeVol Funeral Home, 10 East 21. Signeture of Funerel Service Licen Park Drive, Gaithersburg, MI 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Park Drive, Gaithersburg, MD 20877 Approximete Intervel Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Ewing's Sarcoma **Examiner** Due to (or as a consequence of): Examiner physician and the burial-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or es e consequence of): for use as signed by the a P.O. Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ♥ No Division of Vital I or Attending Physician: after death. Director: After this certifica director 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 ☑ Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Neturel 2 Accident 1 Tyes 2 No 6 Could not be determined n 24 hours after des he Funeral Director hately filled in by the 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homleide 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier To the Mosp within 24 ho To the Fune completely fi Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title D0055748 November 2, 2000 CM FAST 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Evelio Peréz-Albuerne M.D., 111 Michagan Avenue, N.W., Washington DC 20010 31. Date filed (Month, Day, Year) 32. Begistrar's Signeture State oouts Registrar NOV 03 2000

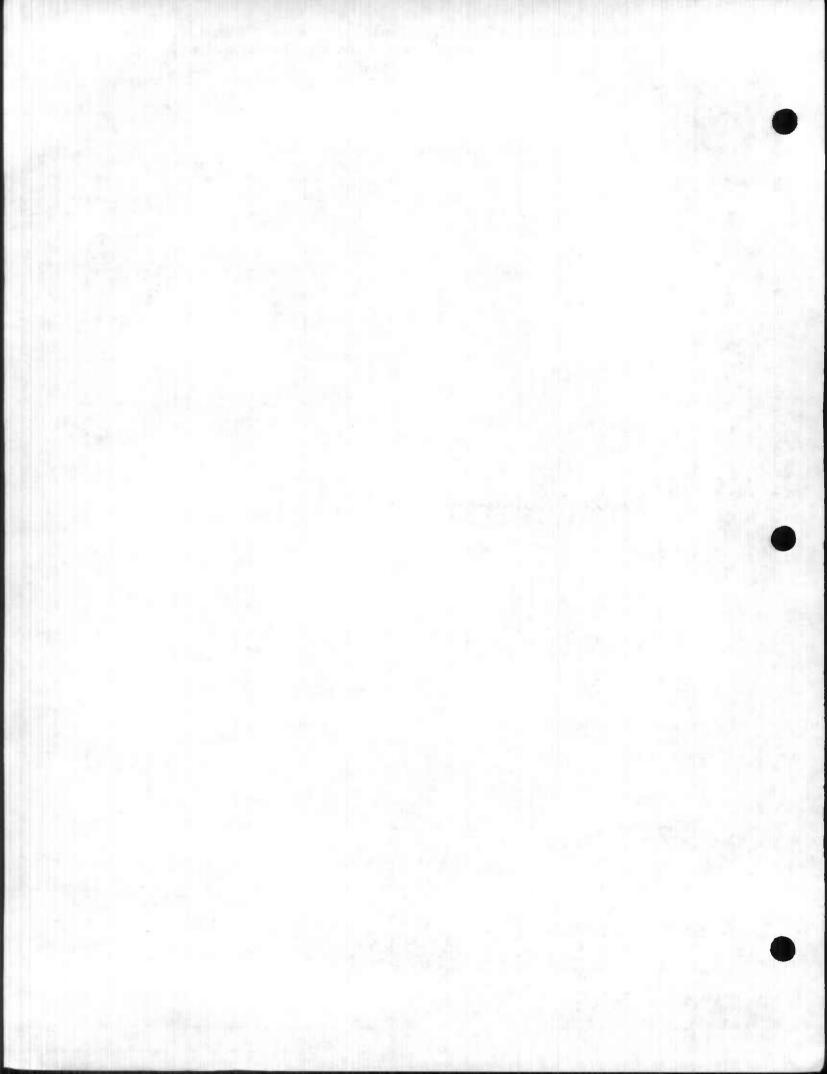


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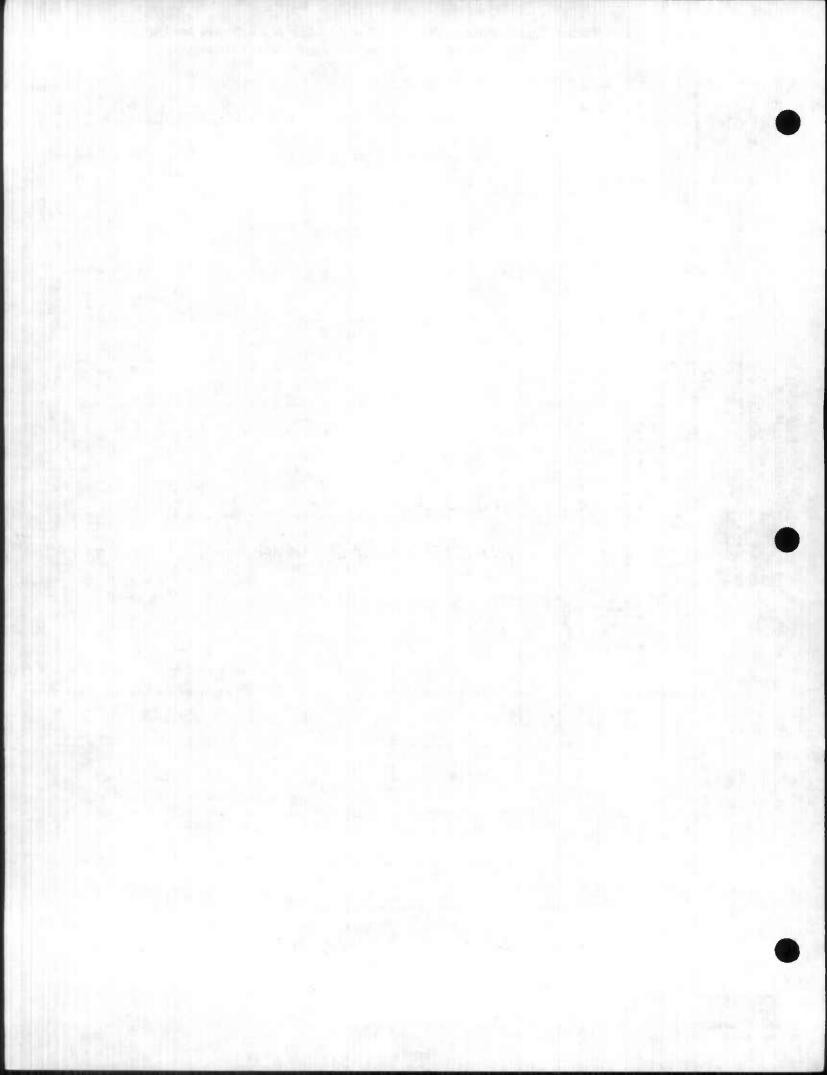
State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 3 6 2 7 2 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3 Time of Death Nov. 2, 2000 **Physician** 5:00 AM Melvin Worsham John /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Name (If not institution, give street and number) Examiner Montgomery Village Montgomery 10111 Watkins Mill Place If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthdey) **Funeral** Deys 1 M 2 F Yrs. 63 217-32-4329 July 21,1937 Wash. D.C. **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or herne 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Montgomery Village Maryland Director Montgomery 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 20886 10111 Watkins Mill Place United States Funeral 12. Was Decedent Evar in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Marital Status hours after 1 XYes 2 No 1959-If Yes, Give 1 ☐ Never Merried 2 ☑ Merried Specify: White 1 Yes 2 XNo Specify: à lf Yes, Give Yaer or Datas: 3 ☐ Widowed 4 ☐ Divorced 1964 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) C & P Telephone Co. Supervisor 12 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Nema (First, Middle, Last) th and Mental
7 is marked o Mental should be Christine 2 Μ. Archie 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 ah Department of Health and Important: If then 27 is m any injury or other traum 0059. 10111 Watkins Mill Place- Montg. Vill., MD. 20886 Deborah E. Worsham - Wife Baltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Data 20c. Location - City or Town, State Nov 4, 1 Burial 2 Cremetion 3 Repoval from State 4 Donation /5 Other (Specify) Parklawn Memorial Park 2000 Rockville, Maryland 21. Signature of Funeral Service Ucensee 22. Nama and Addrass of Facility DeVol Funeral Home 20877 my 10 E. Deer Park Dr., Gaithersburg, MD DER 23a. Perty Enter the diese, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or hand the unit list only one cause on each line. Approximate Interval Betw Onset end Deeth **Physician** Immediate Causa (Final disease or condition resulting in deeth) /Medical 1 YEAR CANCER LUNG Examiner Due to (or as a consequence ot) Examiner attending physician and for use as the bunal-transit certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of) The lew requires that the death signed by the aid Pert It. Other aignificant conditions contributing to death but not resulting in the underlying ceusa given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown þ 24e. Wes an autopsy performed? 24b. Wera autopsy findings available prior to completion of cause of death? Completed peed has page 1 ☐ Yes 2 ☑ No 1 ☐ Yas 2 ☐ No certificate Physician: 25. Wes cese referred to medical axaminer? Be 26. Place of Deeth (Check only one) 1 ☐ Yes 2 No Hospitel: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) To veral Director: After this villed in by the funeral d After this 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Hospital or Attending 1 K Netural 5 Pending investigation 1 Yes 2 No deeth 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) after 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and plece, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and plece, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and 29c. Licansa number 29d. Data signed (Month, Day, Year) 10+1 November 2, 2000 D21359 30. Nema and address of person who completed ceuse of death (flem 23a) (Type, Print) 10 3800 Reservoir Road, NW Washington, DC 20007-2197 Naiyer A. Rizvi, M.D.,

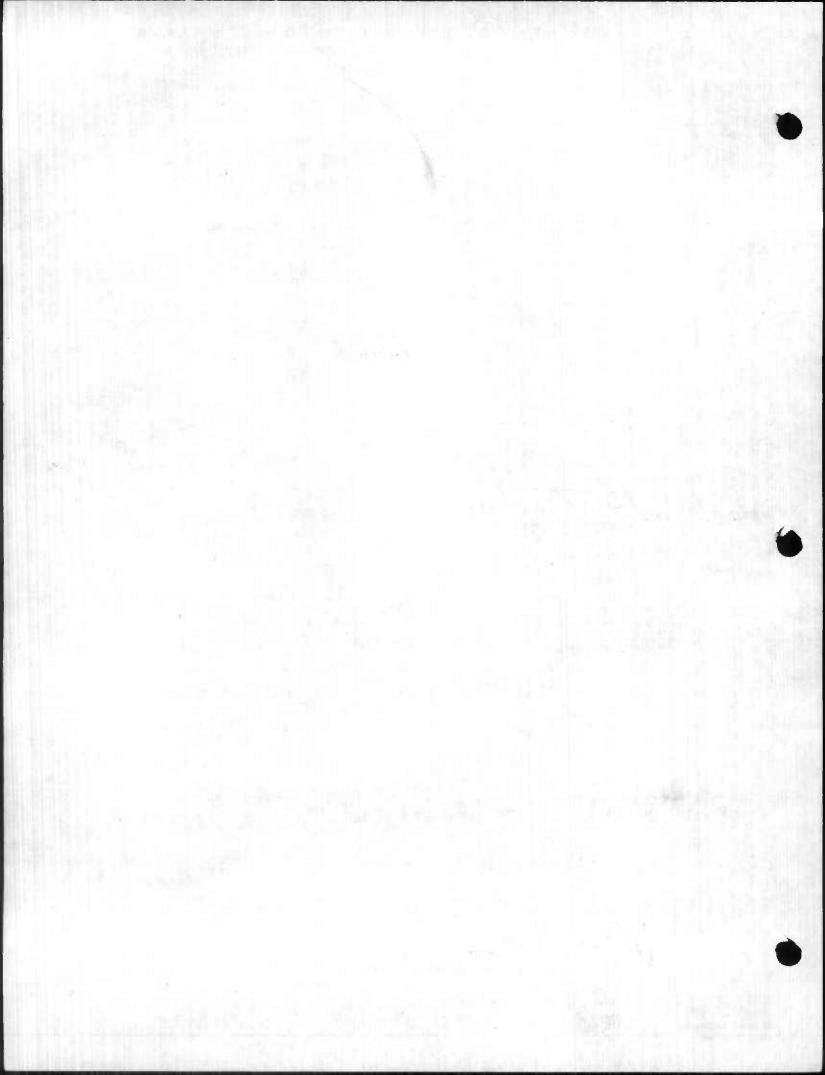
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31. Date filed (Month, Dey, Year)

32. Registrer's Signeture ilneva

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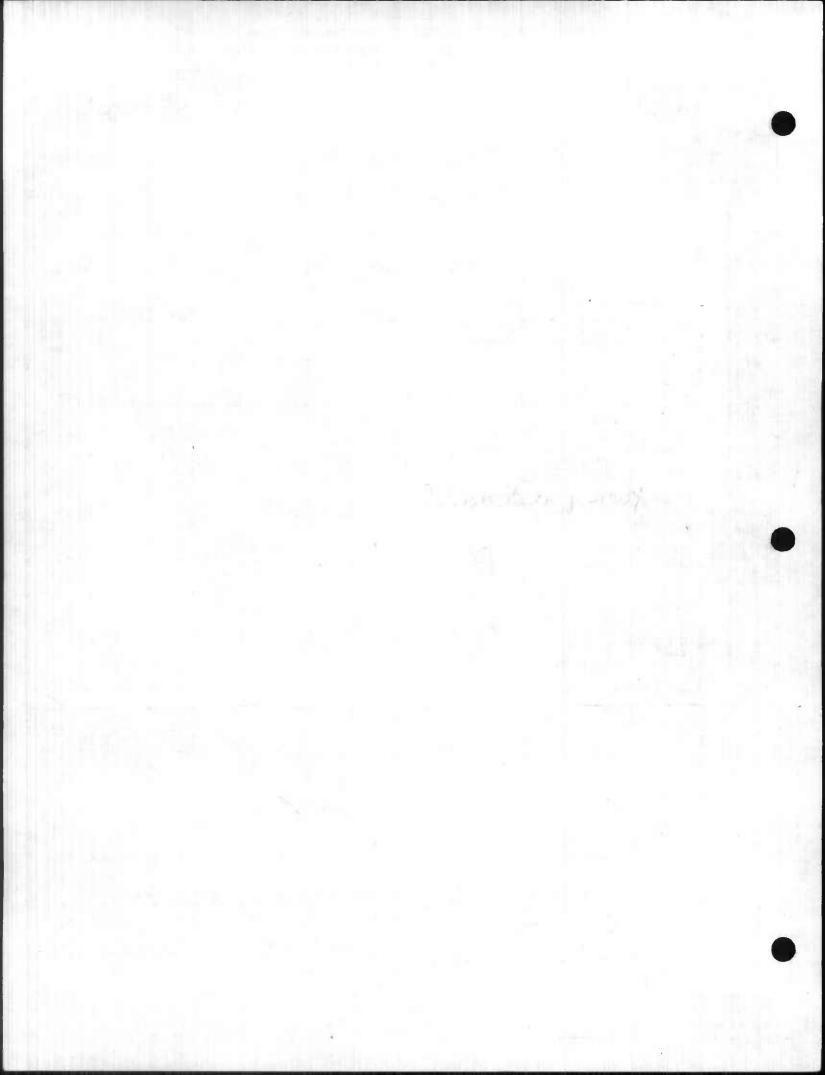


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 1. Decedant's Nama (First, Middla, Last) 3. Tima of Death **Physician** 8:05 A 90m /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not Institution, giva street and number) 4c. County of Death **Examiner** Gaithersburg Wilson Health Care Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) **Funeral** Days Months Hours 1 M 2 F 90 Vrs 30, 579-24-7270 1909 Batesville, Director Nov. Usual Rasidance of Decedant with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f ahow the Medical Examinar must be notified at 1 ☐ Yas 2 🖾 No Director MD Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20760 301 Russell Ave U.S.A. death Funeral 12. Wes Decedent Ever in U.S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11 Merital Status hours after 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 ☐ Nevar Married 2 ☐ Married altimore, Maryland 21215-0020 1 Yas ZENo Specify: White À 3 Widowed 4 □ Divorced pe 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Complet Hygiene. Elementery/Secondery (0-12) Collega (1-4or 5+) Teacher Federal Employee other t pemit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If fiem 27 le marked other any Injury or other treumatic event pace. 17. Fathar's Nema (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) Be W.A. Lanier Della Harris 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Wanda Burnap /daughter 16141 York Rd. Sparks, MD 21152 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Steta **Burial 2 Cramation 3 Removal from Stata Oak Grove Cemetery 10/28/00 Conway, AR 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signatura of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Metropolitan Funeral Service Alexandria, VA 22310 35a Part Emartha disaasa, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, of heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** /Medical Immediate Cause (Final disaase or condition resulting in death) Examine Examiner certificata be executed physician and s the burial-trans Sequentially list conditions, if any, laading to immadiate causa. Entar Undarlying Cause (Disaasa or injury that initieted events rasulting in death) Last Dua to (or as a consequence of): Box 68760. Physician/Medicai Dua to (or as a consequanca of): for usa as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? P.O. 3 Probably 4 Unknown 2 1 Yea 2 No signed I Records. by The law requires 24b. Wara autopsy tindings evailable prior to should should Completed 24a. Was an autopsy performed? completion of cause of death? page 2 s 1 🗆 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to medical axaminar? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidenca 8 Other (Specify) 1 Yas 2 No Certification: To this 28a. Data of Injury (Month, Day Year) funaral 27. Manner of Death 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending invastigation within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be datermined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicide Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Hospital 29a. Certifier 1 Certifying Physician: To tha best of my knowledge, deeth occurred et the time, date end place, and due to tha causa(s) and mannar as stated. Medicai 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29d, Data signed (Month, Day, Year) 29b. Signeture and type of certifies 29c. License number Steven Dolinsky, M.D. 30. Nama and address of person who complated causa of daeth (Item 23a) (Type/Print) arthers burg Ussel 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State 2000 30 Registrar

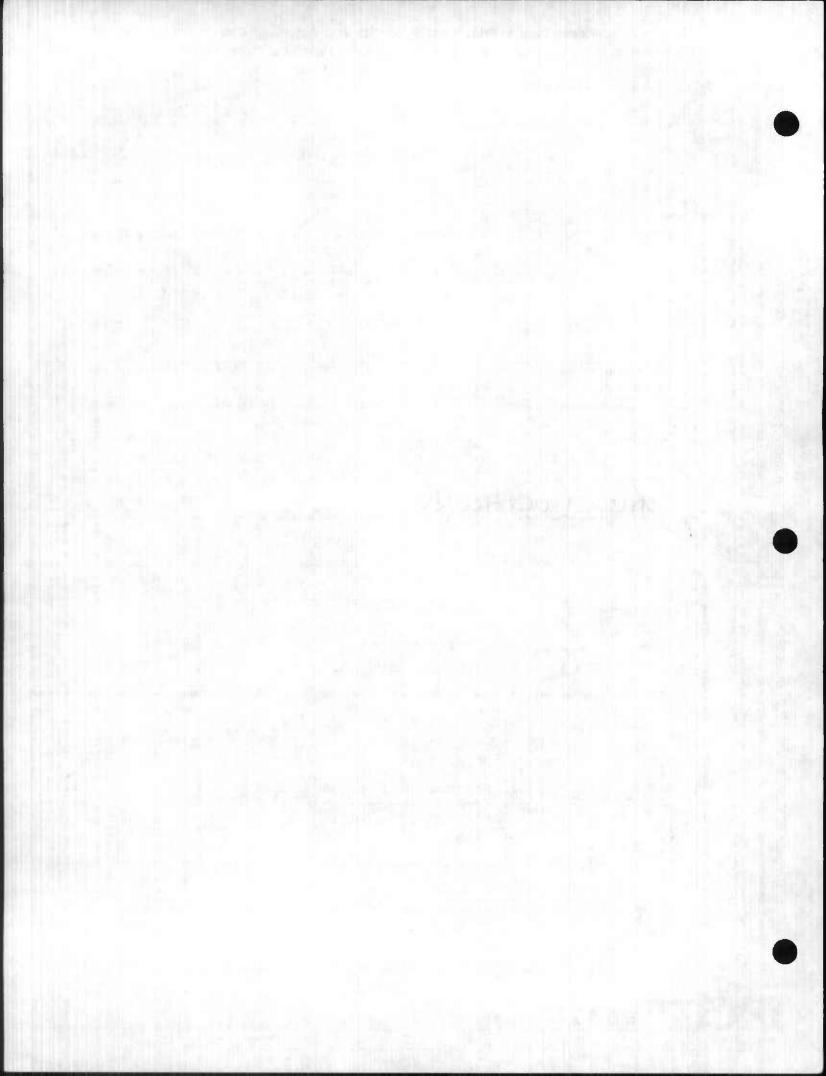
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State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death		Reg. No.	0027.
Dhusisian	Decedent's Neme (First, Middle, Last)	2. Date of Dec	Dey Yea	3. Time of Death
Physician /Medical	Eugene Edward Ward	Vovem	ber 1 282	00 3:27 am
Examiner		, or Location of Death		
	Doctor's Community Hospital Lanha			George
Funeral Director	5. Social Security Number 231-09-1334 6. Sex 1 X M 2 F 89 Yrs. Fi Under 1 Year Fi Under 24 Fi	Hrs. 8. Date of Birt (Month, Day Sept.	15, 1911	inthpleca (State or Foreign Country) North Caroli
2 .	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			t 0d. Inside City Limits
show also				Yes 2□ No
or 28s-f s be notified Director	MD Prince George Riverdale			1
4 55 B	10e. Street and Number 5618 67th Avenue 10f. Zip Code 20737		10g. Citizen of What C USA	Country?
urs after doz aft, or items Examiner in by Fune	11. Meritel Stetus 1 Never Merried 2 Merried 3 Wes Decedent Ever in U,S. Armed Forces? 1 Never Merried 2 Merried 1 Never Merried 2 Merried 3 Wes Decedent of Hispanic Origin If Yes, specify Cuben, Mexican, P 1 Yes 2 No Specify:	? (Specify Yes or No- luerto Rican, etc.)	t4. Race · An Bleck, Wt Specify: B	
od within 72 ho yglene. we than 'natura'. It is Medical.	t 5. Decedent's Education 16e. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of	working	16b. Kind of Business/Industry	
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Co the	7 Printer		Newspape	er
B every		Neme (First, Middle,	Maiden Sumeme)	
Ment arke arke To	Unknown Mart	ha Ward		
pus and	19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number of			, Zip Code)
27 W	Mary Holloman - Daughter 6530 Old Landover	Rd. Landov		0785
nt if he in y or off	20a. Method of Disposition 1 Burial 2 Cremetion 3 Removal from Stete 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Cemetery	11/4/00	Ahoskie,	
arte de la	21. Signature of Funerel Service Licenters 22. Neme end Address of Facility	Metropolit	an Funera	l Service
9558				dria, VA 22310
-	234 Part Hybr the disease, or complications that caused the deeth. Do not enter the mode of dving, such as car			Approximate
husisian	phoul, otheart failure. List only one cause on each line.			Intervel Between Onset and Death
nysician Medical	Immediate Cause (Final			1 10
caminer	disease or condition resulting in death) a. TSDIRah- Unewnan a			mante
- E	Due to (or as e consequenca of):			
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g physician end as the burial-transit ledical Examir	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequenca of): C. Due to (or es e consequenca of):			
cian buria	cause. Enter Underlying Cause (Disease or injury			
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sed f	Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did 1	tobacco uae contribu	rte to the cause of death?
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eral di	27. Menner of Death 28a. Dete of Injury 28b. Time of 28c. Injury at		now injury occurred	
to tun	t Montaurel 5 Pending (Month, Day Year) Injury Work? 2 Accident Investigation M t ☐ Yes 2 ☐ No	111111		
within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)	28f. Location (S City or Tox	Street end Number or vn, Stete)	Rural Route Number,
within 24 hours after death. To the Funeral Director: After completely filled in by the fune fune Medical Certification	29e. Certifier (Check only 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death of			
within 2 To the comple	one) and menner steted. 29b. Signature and title of dertifier 29c. License number		29d. Dete signed (Mo	onth Day Year)
8		60		2000
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DPi NORK SI	136'c 17	MD'	20715
State	31. Date filed (Month, Day, Year) 32. Registrer's Signeture			

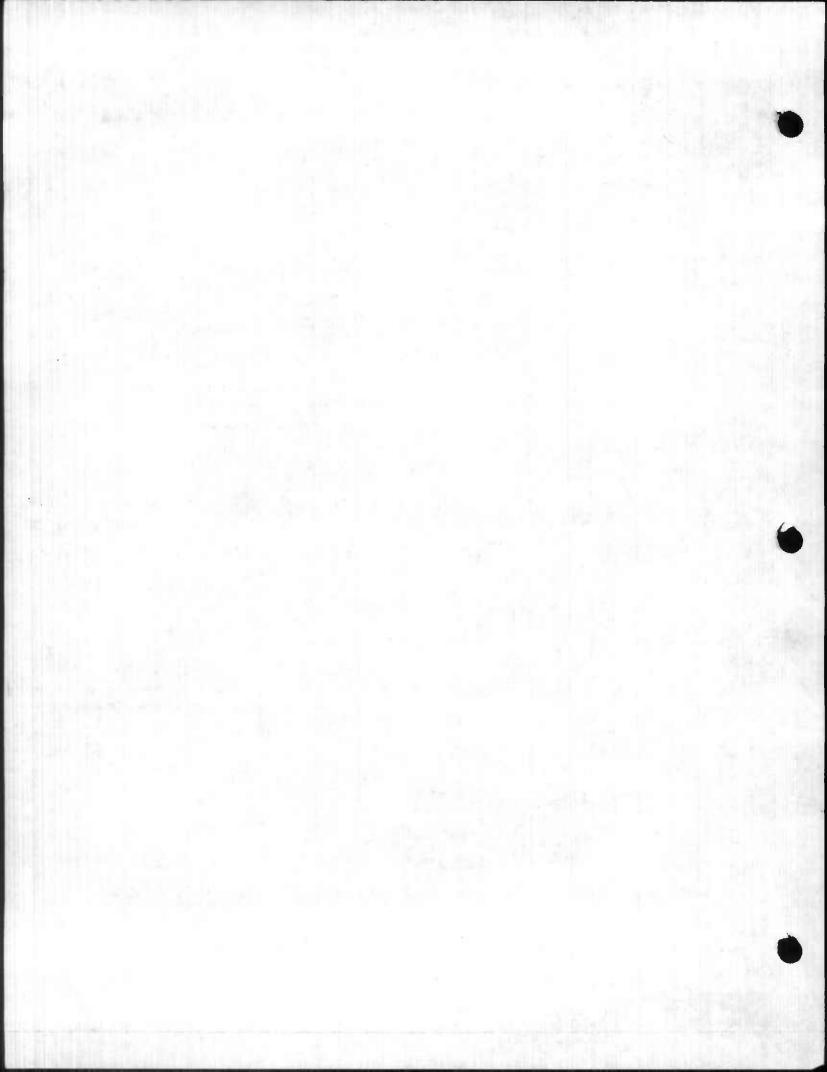


1. Decedent's Nama (First, Midd			Certificate of	Death		giene	36275
	le, Last)				2. Data of De Month	Day	Year 3. Time of De
Charles H. Wa				4b. City, Town, or I	Octobe		
4a Facility Name (If not institution 8412 Donnybroom							
5. Sociel Security Number	6. Sex 7. As	ga (In yrs. last birti	hday) If Undar 1 Yee		8. Dete of Bird (Month, De	Montg	Birthplece (State or For Country)
579-36-5700	112 M 2□ F	70	rs. Months Deys	Hours Min.	Jan 24	, 1930	DC Country)
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							1 □ Yes 2
Maryland Montg	omery	Chevy C	10f. Zip Coda		T	10g. Citizen of V	Whet Country?
8412 Donnybroo	k Drive		20815			USA	
11. Meritel Stetus	12. Wes Decedant	Ever in U,S.	13. Wes Decedent of If Yes, specify Cu	Hispanic Origin? (S	pecify Yas or No		e - American Indian,
1 Nevar Married 2 Mar	Armed Forces:		1 Yes 2 No		o rican, etc.)	Specify	k, Whita, etc.
3 Widowed 4 Divorce	d Yeer or Detes:	1952					white
	nt's Education ast grada completed)	16a.	Decedent's Usuel Occu (Give kind of work don- life. DO NOT use retir	e during most of wor	king	16b. Kind of Bu	usinass/Industry
Elementery/Secondary (0-12)	College (1-4or		structor	90)		Floots	ic Utility
17. Fathar's Nema (First, Middla.	, Last)	111	Structor	18. Mother's Ner	ne (First, Middle,		
Frederick Harv	ey Walck			Blanche	Margare	t Hurle	v
19e. Informent's Neme/Reletion		19b.	Mailing Address (Street				
Elsie A. Walck	/ Wife	84	12 Donnybr	ook Drive	, Chevy	Chase.	MD 20815
20a. Method of Disposition 1 Burial 2 □ Cremetion	2 Damarel from State	20b. Plece of	Disposition (Neme of		Dete	20c. Location -	City or Town, Stata
4 Donetion 5 Other (Arling	ton Nation	al Cemete	ry 2000	Arlingt	on, VA
21. Signature of Juneral Service	Licensee		22. Name end Add Francis J	ress of Facility	Funeral	Home.	Inc
Xobertz	Defe		500 Unive	rsity Blv	d., W, S	ilver S	pring, MD 20
23a. Part . Enter the disease, o shock, or heart feilure. Lis	r complications that cause t only one cause on each I	d the deeth. Do n	ot enter the mode of dy	ring, such es cardied	or respiretory e	rrest,	Approximata Interval Between
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Immediate Cause (Finel disease or condition resulting in death)	a WEIR		2 COL	000 0	twice	4	4 gr
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Sequentially list conditions	6.	Due to (or as e c	onsequence of):	10.00			
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury	A 77 (6) Table						
that initiated events resulting in death) Lest	С.	Dua to (or as a c	onsequenca of):				
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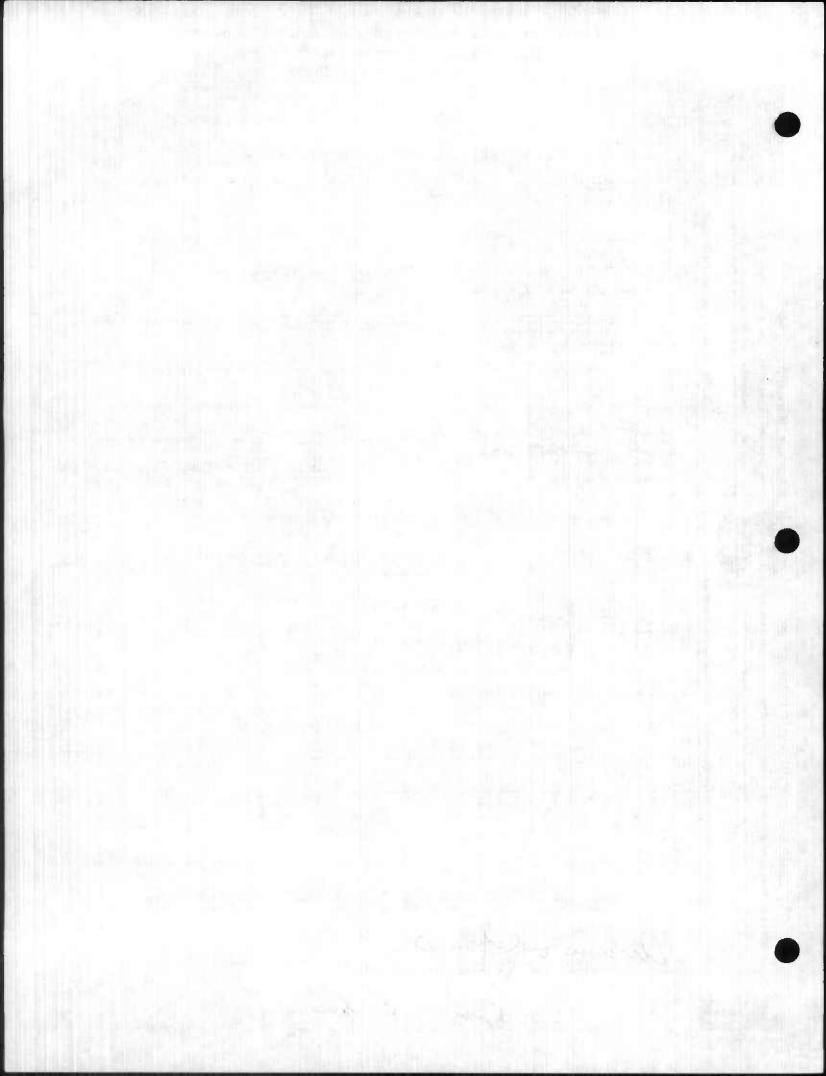
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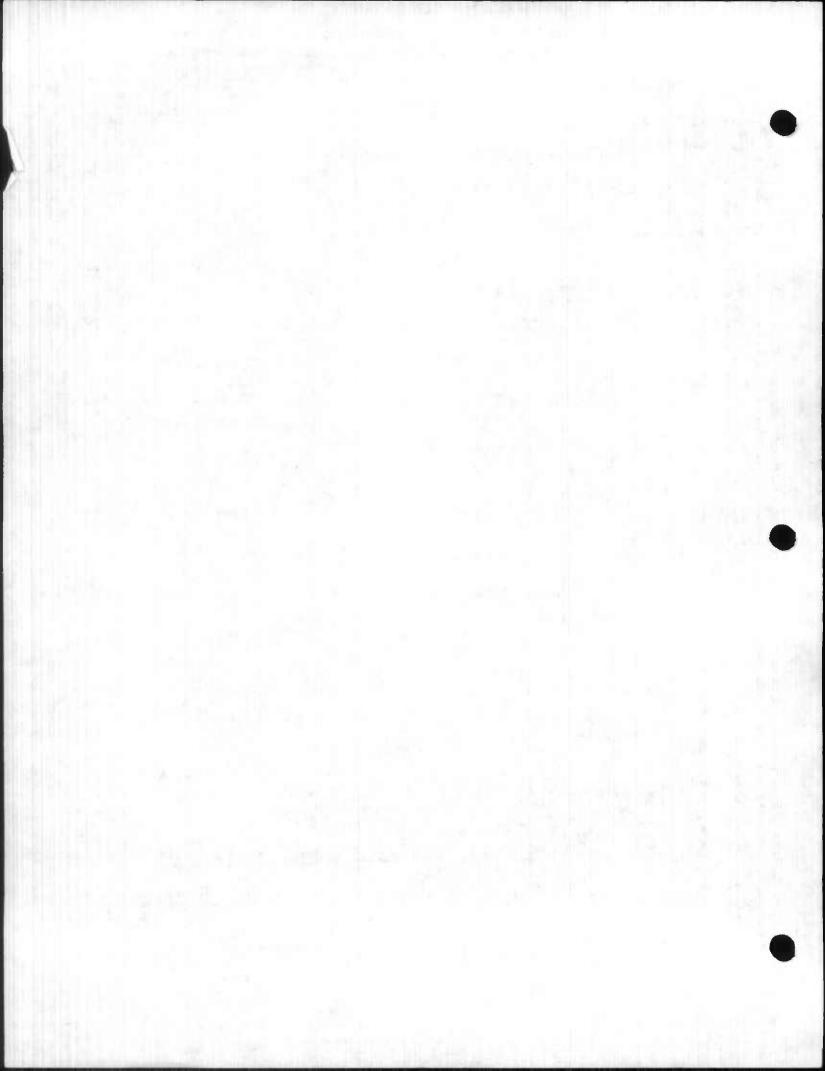
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Day Yaar Month **Physician** Raymond Wright Wahl r 1,2000 4c. County of Death 4:25 A.M November 1 /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not institution, giva street and number) Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year 8. Data of Birth (Month, Day, Year) Dec. 23, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 6. Sex **Funeral** Months Hours 90 Vrs 221-01-2017 1909 Delaware Director Usual Besidence of Deceden the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Example: must be notified at 1 Yes 2 No Director Maryland Frederick Frederick 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 5708 Etzler Road 21702 USA Funeral daath 12. Was Decedent Evar in U.S. Armed Forces? 1 Yes 2 No if Yes, Give 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Pages 1 and 2 should be filed within 72 hours aften of the shall and Mental hygiena.
Instit if them 27 le marked other than "natural", or intry or other treumstic event, the finding Frank. 1□ Yes 2 No Baltimore, Maryland 21215-0020 Specify: White þ 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) self real estate sales 18. Mother's Neme (First, Middle, Meiden Sumame) 17. Father's Neme (First, Middle, Last) Be Julia A. Godwin Fred J. Wahl 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 21702 7207 James Harris Memorial Drive, Frederick, MD Fred H. Wahl, son 20b. Place of Disposition (Nama of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition + Burial 2 Cramation 3 □ Removal from State permit. Page Department o Important: If any Injury or once. Mt. Olivet Cemetery 11/3/2000 Frederick, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licen Keeney and Basford Funeral Home Mooass 106 East Church Street, Frederick, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** Immediete Cause (Finel disease or condition resulting in deeth) /Medical luh Examiner Due to (or as a consequence of) Examiner burial-transit Sequentially list conditions, if any, leading to immadiate ceuse. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last and Due to (or es e consequence of) attending physician Box 68760. certificete be Physician/Medical the Due to (or as a consequence of): 88 use 23b. Did tobacco use contribute to the cause of death? P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. the 1 Yee 20 No 3 Probably 4 Unknown yd bengis Division of Vital Records. by 8 The law requires 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? page 2 should Completed has 20 No 1 Yes 1 ☐ Yes 2 ☐ No certificate 25. Was cese referred to medice examiner? Be 26. Piece of Deeth (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1-2 Inpatient 2 ER/Outpatient 3 DOA 10 28e. Dete of Injury (Month, Dey Year) To the Hospital or Attending P? within 24 hours after death.
To the Funeral Director: After it completely filled in by the funeral 28b. Time of Injury 28d. Describe how Injury occurred 27. Menner of Deeth 28c. Injury at Work? Certification: After t Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide edical (29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end menner stated. (Check only one) 29c. Licanse number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier D09689 00 611 30. Name and address of person who completed cause of seath (Item 23a) (Type, Print) 300 West 9th Street Frederick, Maryland 21701 Austin Pearre, Jr. 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State Registrar NOV 0 2 2000



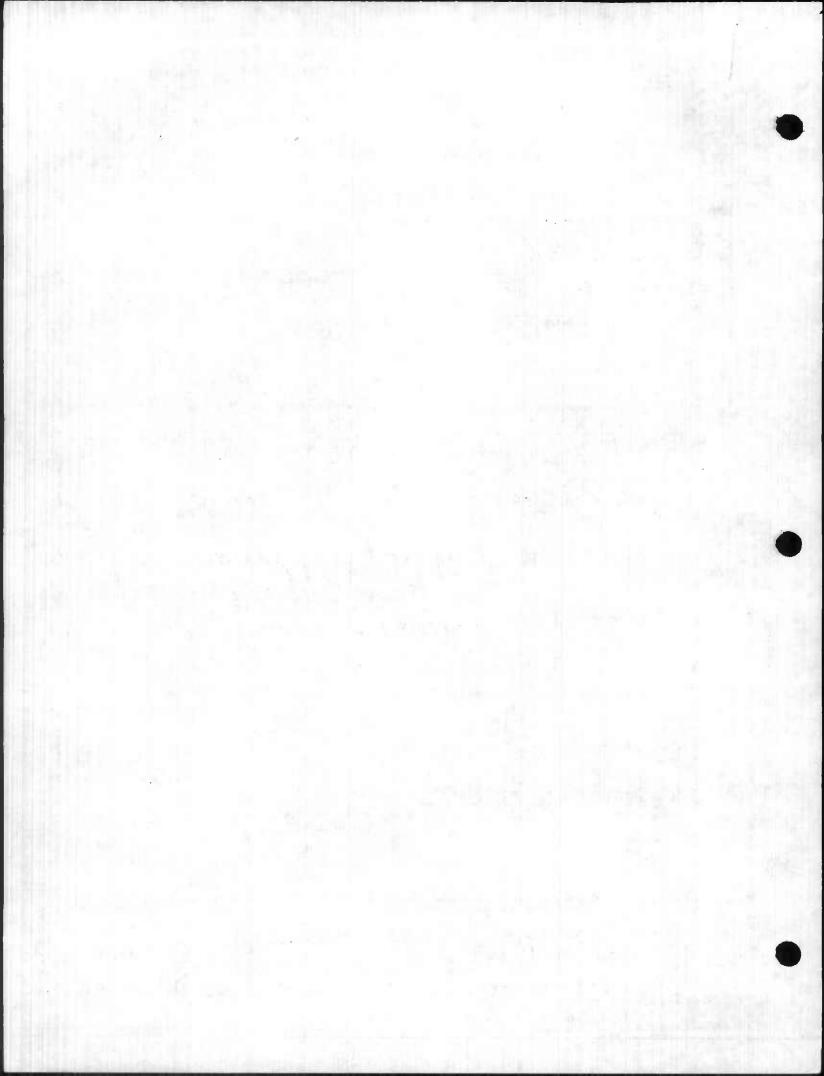
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Qing-Ying Zhang 25, October 2000 1:43 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care-Potomac Potomac Montgomery Months Days If Under 24 Hrs. 8. Date of Birth
(Month, Dev. Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F 68 578-06-8048 Director China December 23, 1931 Usual Residence of Deceden 10a State 10c. City, Town or Location 10d. Inalde City Limita 10b County r than "natural", or Name 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Maryland Montgomery Rockville Directo 8 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2000 McAuliffe Drive 20851 China Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. 11. Marital Status Black, White, etc. hours after 1 Never Married 2 Married Specify: Chinese Baltimore, Maryland 21215-0036 1 Yea 2 No Specify: ð 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 22 (Give kind of work done during most of working life. DO NOT use retired) flad within 7 Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Cafeteria Worker Food Service 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Last) Be should be and Mental is marked Chung Zhang Pong Shu 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) pu 19e. Informent'a Neme/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is n Chien Shu Chien 2000 McAuliffe Drive Rockville, MD 20851 20b. Place of Disposition (Neme of cametery, cremetory or other pleca) 20c. Location - City or Town, State 20a. Method of Disposition October 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State 27,2000 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, MD 20850 e of Funeral Service Licenses M00092 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) MOS-Examiner a# a consequence of Physician/Medical Examiner attending physician and for use as the burial-transit certificate be executed Sequentially list conditiona, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last Due to (or as a consequence of) Box 68760. Due to or as a consequenca of): that the death ed by the a Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Records, þ 90 24b. Were autopsy findinga available prior to completion of cause of death? should ! 24a. Was an autopsy performed? Completed certificate has page 2 The 1 Yes 2 No 1 Yes 2 No Division of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) all or Atternants after death.

Are Director: After this ce To Hospitaf: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2PNo 28a. Date of Injury (Month, Dey Year) 27 Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, end due to the cause(s) end menner as stated.
2 Medical Examiner: On the basia of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hosp within 24 hou To the Fune completely fi edical (Check only one) 29b. Signeture and title of certifie 29c. License number 30. Name and address of person who so pleted cause of death (Item 23a) (Type, Print) AROOP.

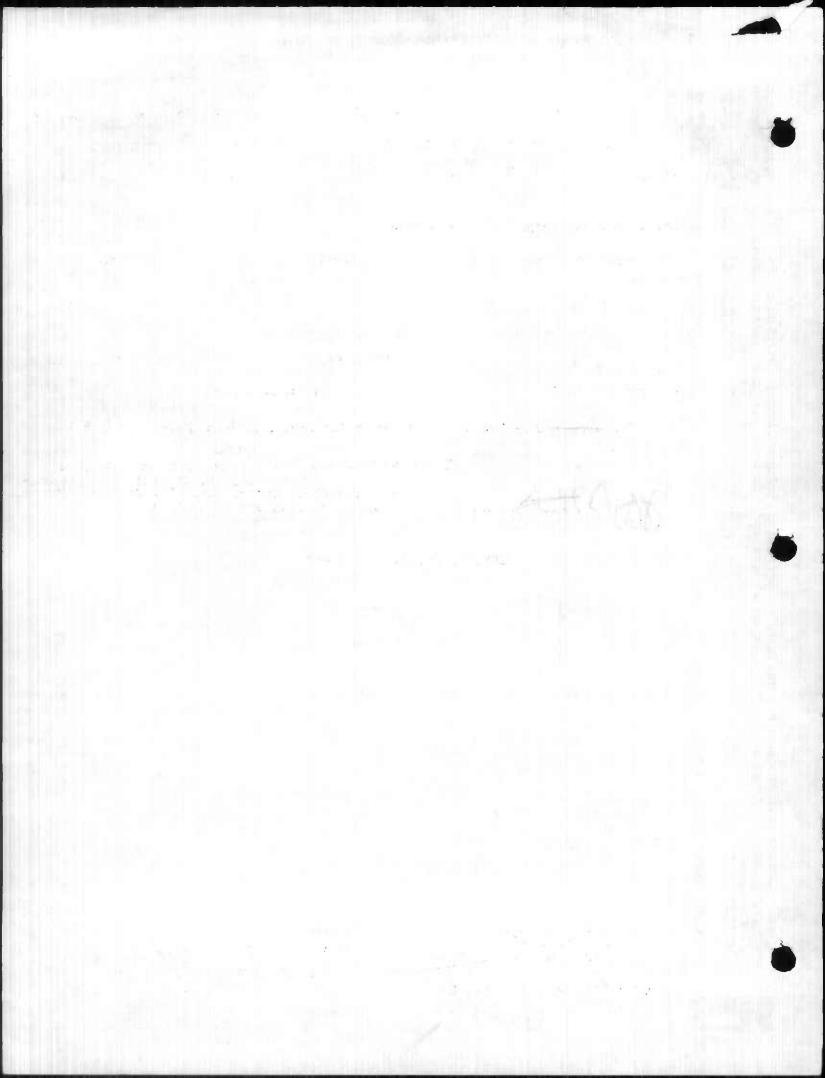
State Registrar 31. Date filed (Month, Dey, Year)

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32. Registrar's Signature



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. AMEND ITEM: #1 PER PHY G789 11-21-00 State of Maryland / Department of Health and Mental Hygiene amend item 24a,25 per me G789 11/15/00 yf Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death EDMOND A. ANAIR III OCTOBER 28, 2000 Physician - EDMOND A AMAIR III /Medical 4b, City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Death Examiner CATONMANOR GENESIS ELDER CARE BALTIMORECIT 8. Date of Ban, Year) (Month, Day, Year) 19, 1946 5. Social Security Number If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) MD **Funeral** 1MM 2□ F Months Days 216-44-5903 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1X Yes 2 No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Name 23a 3330 Wilkens Avenue 21229 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married d other than "natural", or event, the Medical Exami Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) chef restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) unk Be Edmond A. Amair II 19a. Intormant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Kathy Olsen/friend 25 Egges Lane Baltimore, MD 21228 20b. Place of Disposition (Nama of cematery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) IN STA in state Ronald S. Wade 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore Street Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or haart failura. List only one causa on aach lina. Approximata Intarval Batween Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) helucour Lxaminer LAN Examiner The law requires that the death certificate be executed ician and burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by Sign Completed 24b. Ware autopsy tindings available prior to 24a. Was an autopsy completion of cause of death? 1 Yes 2 No 1 Yes 2 No Be 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 Yes 2√ No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Divatural 2 Accident 5 Pending investigation 1 Tes 2 No

Box 68760, P.O. Division of Vital Records. or Attending Physician: 24 hours after death.

Funeral Director: A Hospital completely within 2 To the eg.

EDMOND

29a, Certifier 1 Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and mannar as stated. (Check only one) miner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 30. Nama and address son who co Reted cause of death (Item 23a) (Type, Print)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar 31. Data tiled (Month, Day, Year) 5 2000

6 Could not be detarmined

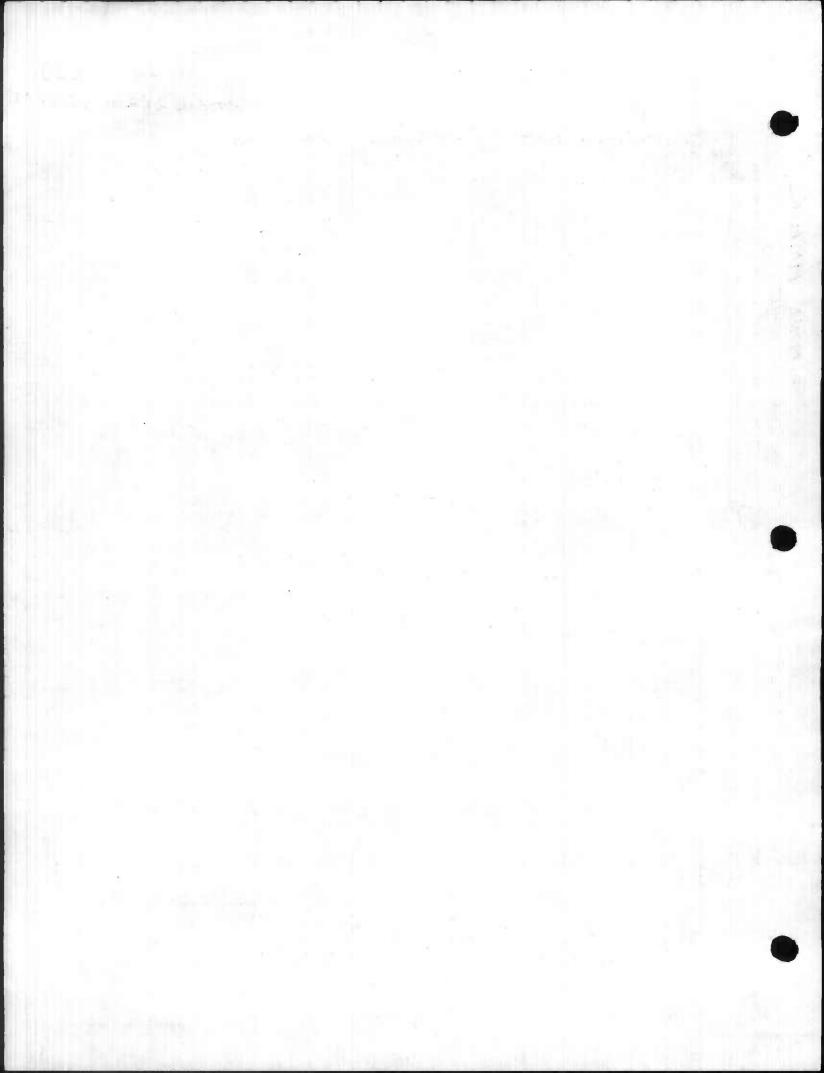
3 Suicide

NOV 1

4 Homicide

32. Registrar's Signature

28a. Place of Injury - At home, tarm, street, factory, office building, atc. (Specify)

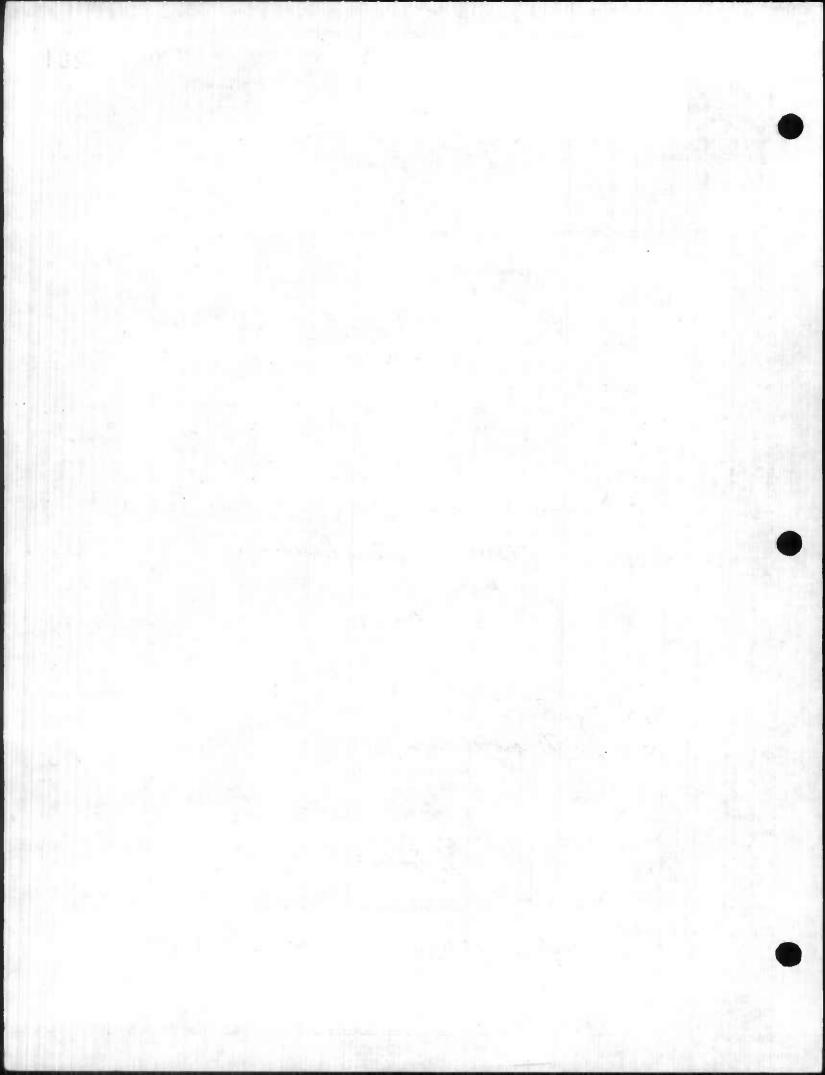


State of Maryland / Department of Health and Mental Hygieneo

Physician	1. Decedent's N	Neme (First, Middle, Las	it)				HELL	2. Date of Deal Month		Year	3. Time of Death
/Medical	Lero	4			erson			Nov.		000	10:51am
xaminer	100 000 000	ne (If not institution, give)r)		1	tb. City, Town, or L		4c. County		
	5. Social Securi	y Medical		Age (In yrs. la:	et hirthday) If Und	er 1 Yeer	Baltimo			NA 9 Birtho	lace (State or Enrain
neral ector		46-6221	X M 2□ F	54	Yrs. Month		Hours Min.	8. Date of Birth (Month, Day) 11-15-	-45	Coun	lace (State or Foreig try) MD
or or	10a. State MD	10b. County NA			Town or Location	57	- N - 2		abole.	1	0d. Inside City Limit
be notified Director	10e. Street and					ip Code			0g. Citizen of V	What Coun	
2 0	250	S. Dallas	Court			1231			USA		.,,
iner must Funeral	11. Maritel Stat		12. Wes Deceder	nt Evar in U,S.	Evar in U.S. 13. Wes Decedent of Hispanic Origin? (S						
by Fur		Merried 2 Married	Armed Force: 1 Yes 2 the Yes, Giva Year or Date:	No		ecity Cube	Specify:	Rican, etc.)	Specify: Black		
		15. Decedent's Ed	ucation		16e. Decedent's Usual Occupation						
r, the Medical	Flementary/S	Specify only highast gradescondery (0-12)	de completed) College (1-4o	r 5+)	16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)						
Man In	10th		NA	144	Dept. of Sanitation				Balti	more	City
Be (17. Father's Ne	ma (First, Middle, Last)					18. Mother's Nam	e (First, Middle, I	Maiden Sumem	ia)	
To B	Raymo	ond G	ross				Ossie			ders	
1		's Name/Reletionship (7									Code) 2123
the tr	Janee		rson	001 51	250 S.						
10 10	20a. Method of	2 Cremation 3	Removei trom Stell	(0)	ce of Disposition (Ninetary, cremetory of				20c. Location -		
1		on 5 Other (Specify		Vos	shell Me		1.	11-16-2	2000 Di	unda	lk,MD
any in	21. Signeture of	of Funerel Service Licen	see				ss of Fecility E March FF			_	and 2120
	23a. Pert1. En	tar tha diseesa, or combeent tellure. List only	licetions that caus	ed tha daeth.						CII P	Approximete Interval Between
ician dical niner	tmmediate Ceu disease or con resulting in dea	use (Finat dition			Arten	1 20	seose			1	Onsat and Deeth
al-transit Examiner			A	Nuth	muas						12 yrs
ran tran	Sequentially lis	it conditions,	11	Du to (or i	as g consequence o	1					
	Sequentially list any, leading cause. Enter L Cause (Diseas that initiated ev	Inderlying e or injury	c. LA	Men	rensur	n			1500	1	2042
di p	that initiated ev resulting in dea	ents ith) Last		Due to (or a	is a consequence of):					/
da b			-								
of for use a	Port II. Other al	unificent conditions co	d	but not result	ing in the underlying	cause giv	ren in Part f.	23b. Did to	obacco ues co	ntribute to	the cause of deat
o detached for use a	Pert II, Other al	gnificent conditions of				cause giv	ven in Part f.	23b. Did to	,		
to detached for by Physicia	Pert II. Other all		ontributing to death			j cause giv	ren in Part f.		2 No	3 Prol	bebly 4 Unkno
	Port II. Other all					j cause giv	ren in Part f.	24a. Was a	2 No	3 Pro	bebly 4 Unkno
	Pert II. Other all) cause giv	ren in Part f.	24a. Was a	in eutopsy med?	3 Prol	bebly 4 Unknown under a utopsy tindingseilable prior to mpletionyof cause
	End Hy 25. Was case of examiner?	2Styc R	Peril S Trypoii	lisin	n	Ott	26. Pleca ot Dec	24a. Was a perior	an eutopsy med?	3 Prod 24b. W. av co of	ere autopsy tindings eilable prior to mpletion of cause dealt?
If director, page 2 should To Be Completed	End Hy 25. Was case of examiner? 1 Yes	Styc Reparation of the second	hypoid Hospitat: 1 Inpa	liston liston tient 20	R/Outpatient 3 🗆	DOA Ott	26. Pleca ot Dec	24a. Was a perior 1 Yeth (Check only or ome 5 Resident)	en eutopsy med?	3 Prod 24b. Wo av co of 1 [ere autopsy tindings eilable prior to mpletion of cause dealt?
If director, page 2 should To Be Completed	25. Was case reaminer? 1 Yes 27. Manner of the statural 2 Accide	elerred to medical No Seein 5 Panding investigation	Hospitat: 1 Inpa	lians	n	DOA Oth	26. Pleca ot Dec	24a. Was a perfor 1 Y th (Check only or ome 5 Residence to the characters)	es 2 No es 2 No es 2 No es 2 No es 6 Oth ow Injury occur	3 Prod	bebly 4 Unknown under autopsy tindings eilable prior to mpletion of cause death?
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tely filled in by the funeral director, page 2 should lical Certification: To Be Completed	25. Was case reamine? 1 Yes 27. Manner of 1 2 Accide 3 Suicide 4 Homici	eterred to medical No Deeth 1 Could not be determined 1 Certifying Phy 2 Medical Example	Hospitat: 1 Inpe 28a. Deta of tr (Month, I 28e. Pleca of building, yelcfan: To the besidner: On the basis	Lians Itient 20 July Jay Year) Injury: At home etc. (Accepts) st of my knowl of examinetic	R/Outpatient 3 (2) Bb. Time of M Be term, street, fector of the street	DOA Ott	26. Pleca of Decier: 4 Nursing H y at k? Yes 2 No	24a. Was a perfor 1 Yeth (Check only or ome 5 Reside 28d. Describe has 28f. Location (S City or Tow)	es 2 No es 2 No es 2 No es 2 No es 6 Oth ow injury occur treet and Numb	24b. Www.co. of 1[] let (Specified anner as send due to different as send due to different anner anne	bebly 4 Unknown under the utopsy tindings eliable prior to impletion of cause death? Yes 2 No
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he Funeral Director: After this centificate has been a pleiely filled in by the funeral director, page 2 should edical Certification: To Be Completed	25. Was case rearmine? 1 Yes 27. Manner of 1 1 Accide 3 Suicide 4 Homici 29e. Certifier (Check only one)	elerred to medical Deeth S Panding Investigation C Could not be determined Certifying Phy Medical Exam and title of certifier	Hospitat: 1 Inpe 28a. Deta of tr (Month, I 28e. Pleca of building, yelcfan: To the besidner: On the basis	Itient 200 and a second and a s	R/Outpatient 3 (2) Bb. Tima of M Be term, street, fectors and/or investigation	28c. trijur Word 1 Dory, office ord et the time on, in my constitution of the constitu	26. Pleca of Decier: 4 Nursing H Yat K? Yes 2 No me, date end place spinion, deeth occu	24a. Was a perfor 1 Y th (Check only or ome 5 Reside 28d. Describe h 28f. Location (S City or Tow) and due to the correct et tha time, of 2	es 2 No in eutopsy med? es 2 No ne) ence 6 Ooth ow Injury occur treet and Numb (Sale) ausa(s) and ma lata end placa,	24b. Www.co. of 1[] ler (Specifiered anner as send due to 4 Month, 206	ere autopsy tinding eilable prior to mpletion of cause dealt? Yes 2 No

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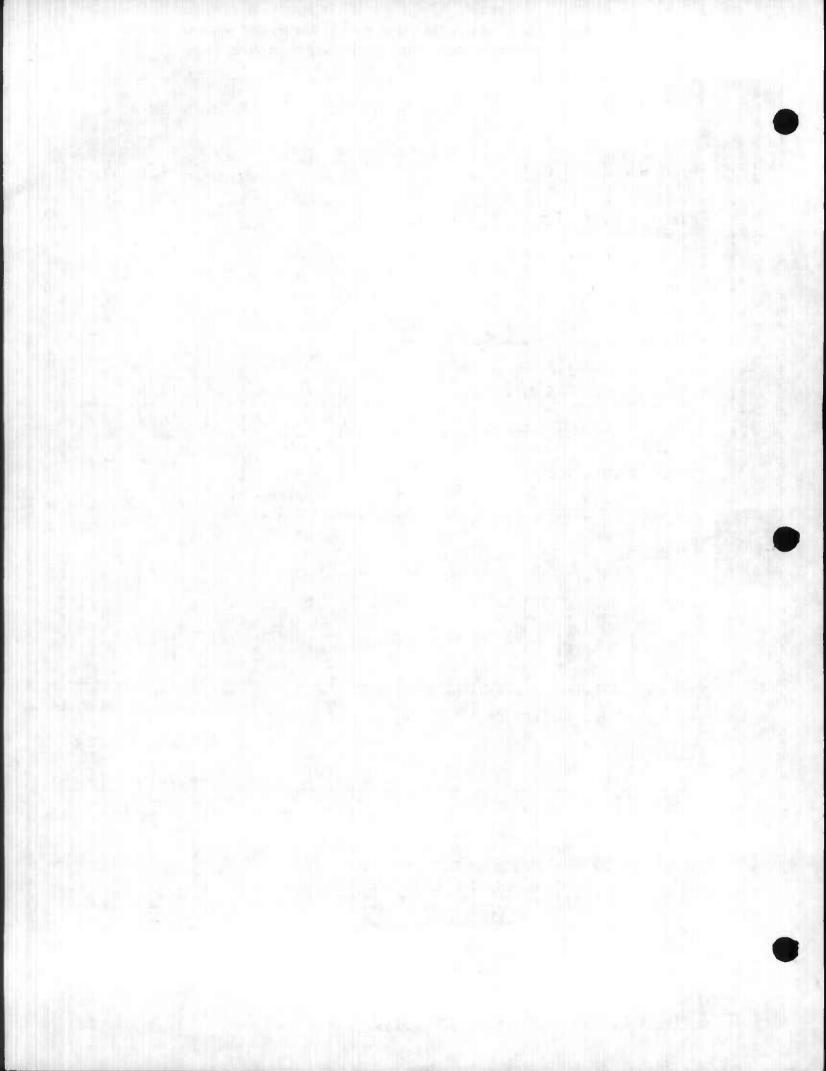
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

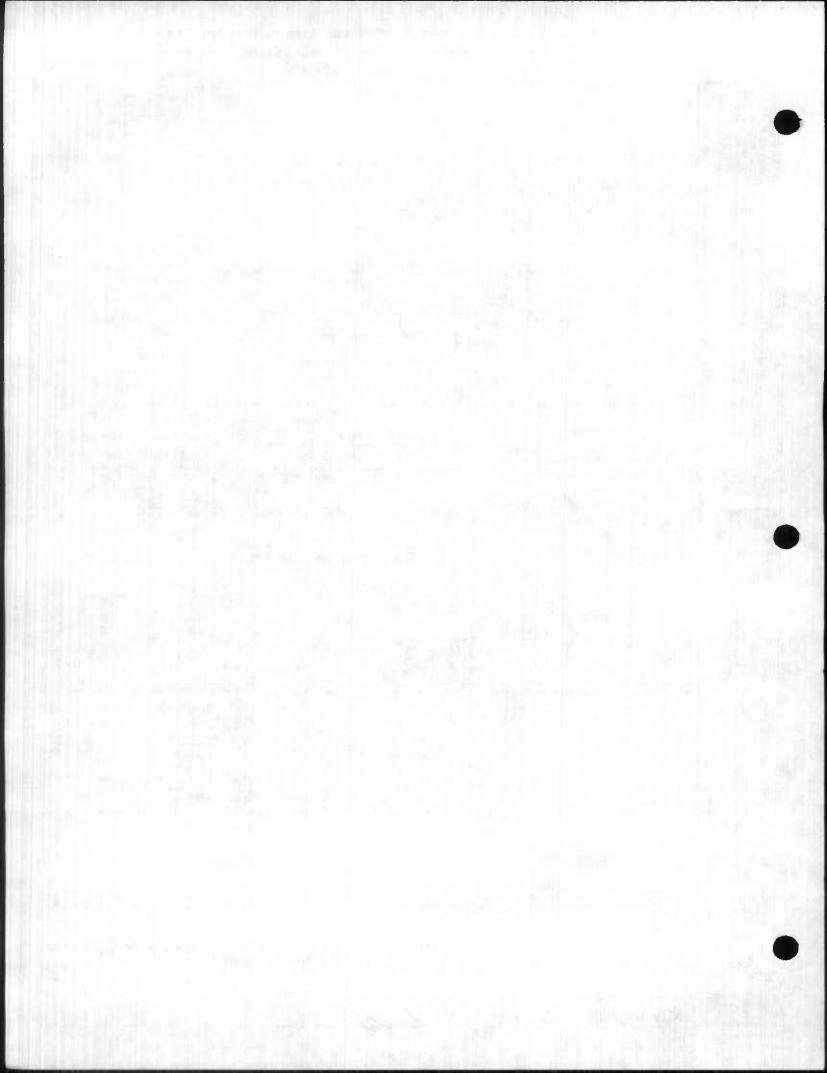
36282

			Certificat	e of Death		Reg. No.	
	1. Decedent'a Neme (First, Middle, Last)	ACCULATION S			2. Dete of D		3. Time of Death
Physician	ELLSWARTH	S ADAMS			No VEM		ומים ו'.40 פרעים
/Medical	4a Facility Neme (If not institution, give s			4b. City, Town	, or Location of Dea		
Examiner	2811 DUNGLE			Dan-	FILLORIE		TIMORE
			st hirthday) If Under		TIMURE		
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. la:	Yrs. Months		Min. (Month, D	ey, Year)	Birthplace (State or Foreign Country)
Director	219771653	2)	113.		14/15	- 42	Ma
2 .	Usuel Recidence of Decedent 10a. Stete 10b. County	I soo City	Town or Location				10d. Inside City Limits
anyla show	Total Stelle		. 1 1				
the Maryla 28s-f sho notified at	IMA BALTO	Do	INDALK				1 ☐ Yes 2 ☐ No
with the Ma or 28a-fs be norther	10e. Street and Number		10f. Zip	Code		10g. Citizen of Whe	t Country?
th wit	2811 DUNGL	LEN Pt.	12.	1222		4.5	. A
		12. Wes Decedent Ever in U.S.	., 13. Wes Dece	dent of Hispenic Origin	? (Specify Yes or N		American Indian,
ter des	1 Never Merried 2 Merried	Armed Forces?	If Yes, spe	city Cuben, Mexican, F	Puerto Rican, etc.)	Bleck, V	White, etc.
o20 ors aft or set by F	3 ☐ Widowed 4 ☐ Divorced	IT YES CAMA	80 1□Yes	2 No Specify:		Specify:	Black
			16a, Decedent's Usua	al Occupation		16b. Kind of Busin	ess/Industry
15.	15. Decedent's Educ (Specify only highest grade	completed)	(Give kind of wo	rk done during most of se retired)	f working		
od within 72 ho or than "naturn it, the tradical Completed	Elementery/Secondery (0-12)	College (1-4or 5+)	TRUC	K Dru	ver	DeNN	15 TRUCKIN
C Resided	17. Father's Name (First, Middle, Last)					e, Maiden Sumame)	
be filed other event,	17. Patrier Warrie (Pirst, Middle, East)	1		16. Mollier S	Traine (First, Micon	e, Maloeri Surname)	1
Via Men Men To	WILLIAM MC	IAMS		MA	RYE	1000	J
Maryland 212 d 2 should be filed with th and Mental Hygiens, the marked other there treumetic event, the treumetic	19a. Informant's Neme/Reletionship (Typ	oe, Print)	19b. Meiling Address	(Street and Number of	or Rurel Route Num	ber, City or Town, Sta	te, Zip Code)
≥ p=22	MARGELENE	Adams	2811	DUNGLE	NCT 1	Jundalk.	1111 21222
of Heal	20e. Method of Disposition	0.00	ace of Disposition (Nermetery, cremetory or o	ne of when pleaded The	Dete	20c. Location - City	y or Town, Stete
	1 ■ Burial 2 □ Cremetion 3 □ R 4 □ Donetion 5 □ Other (Specify)	emovel from State	3. 111 11		11/14/0	Cronnot	4llo Mid
Baltimo	21. Signeture of Funeral Service License	CK		d Address of Facility	N. T.	1 6/10/1/01	11
Balt permit. Depart Importa any Inju	21. Signature of Furieral Service License	0 60)	Id Address of Facility	1. Ch. 3	1: 1000	19 1/6
_ 40244	1 oslah B	· Kocks for	Torep	17. U.	eta Ju	14 1304	n 1 Onbry
	23a. Part 1. Enter the disease, or compli- shock, or heart feilure. List only on	cetions thet caused the deeth.	Do not enter the mod	le of dying, such es ca	rdiac or respiretory	errest,	Approximele Interval Between
Physician	Shoot, or hoof rollard. Elst only or						Onset and Deeth
/Medical	Immediete Cause (Finel	/ENT ON	A. A.	RHYTHA			Claboural
Examiner	disease or condition resulting in deeth)			76 F17 171 K	1114		SUDDEN
6		Due to (or	es a consequence of):				1
x 68766, sertificate be associated ding physician and se as the burial-transit	_ b						
Xar Il-tra	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	es a consequence of):				
600 a be a burie burie	Cause (Diseese or injury						
x 68760, serificate be assected ding physician and se as the burial-transit	that initiated events resulting in death) Last	Due to (or	es e consequence of):				
X 6 Sentific sentific sentific sentific Me							
. 0 00 =	Pert II. Other eignificant conditions con	tributing to death but not result	ting in the underlying of	euse given in Pert I.	23b. Die	d tobacco use contri	bute to the cause of death?
P.O. hat the de by the detached detached	21445				10	Yee 2□ No 3	Probably 4 Onknown
	DIMETES ME	LUITUS					
dS, ulres	111				24a. Wa		4b. Were autopsy findings
cord require been si should leted	HYPERTENSIO	~	100		per	formed?	available prior to completion of cause
Il Records, P.O. The law requires that the tale has been signed by the page 2 should be detached.						/	of deeth?
The transfer has page	STROKE				10	Yes 2 AMo	1 ☐ Yes 2 ☐ No
Vital Indicion: The conflicate rector, pag	25. Wes cese referred to medical			26. Place o	Deeth (Check only	one)	
Of Vita Physician: this certifical ral director,	axaminer?	lospitel: 1 Inpatient 2 E	R/Outpatient 3 Do	OA Other: 4 Nurs	ing Home 5 He	sidence 6 Other ((Specify)
Physical of the Physical of th	27. Manner of Death	28a. Dete of Injury (Month, Dey Year)		28c. Injury at Work?	28d. Describe	how injury occurred	
Attending In death. Sctor: After by the funerification:	1 Netural 5 Pending 2 Accident investigation	(Month, Day Fear)	Injury M	1 Yes 2 No			
dea ctor y the y the	3 ☐ Suicide 6 ☐ Could not be	28e. Plece of Injury - At hon	ne, ferm, street, factor	y, office			or Rurel Route Number,
Division of Vital Records, ne trooptal or Attending Physician: The law requires the Funeral Director: After this certificate has been signe pletely filled in by the funeral director, page 2 should be edical Certification: To Be Completed by	4 Homicide	building, etc. (Specify)			City or To	own, Stete)	
Tilled at the Co	29e, Certifier 1 Certifying Phys	Inter-Tenth Land of the In-			- I	(-)	
Fun Fun	(Check only 2 Medical Examin	lcian: To the best of my know er: On the basis of examinetic					
Division To the Hospital or Attendin within 24 hours after death. To the Funeral Director: An completely filled in by the ful Medical Certificatic	one)	and menner steted.					
To the To the Common	29b. Signeture and title of certifier	1/00	29	c. License number		29d. Dete signed (A	
	tredent &	other MD		D50519	D	NOVEMBE	FR 14, 2000
A	30. Neme and address of person who co	mpleted cause of death (Item :	23a) (Type, Print)	0			
	FEFOFRING VITIES			GET BA	TIMORE	MD 21	2.01
State	31. Date filed (Month, Dey, Year)	32. Registrer's Signatu		or.	-11-10100	1.0 211	
State	NOV 1 5 2000						



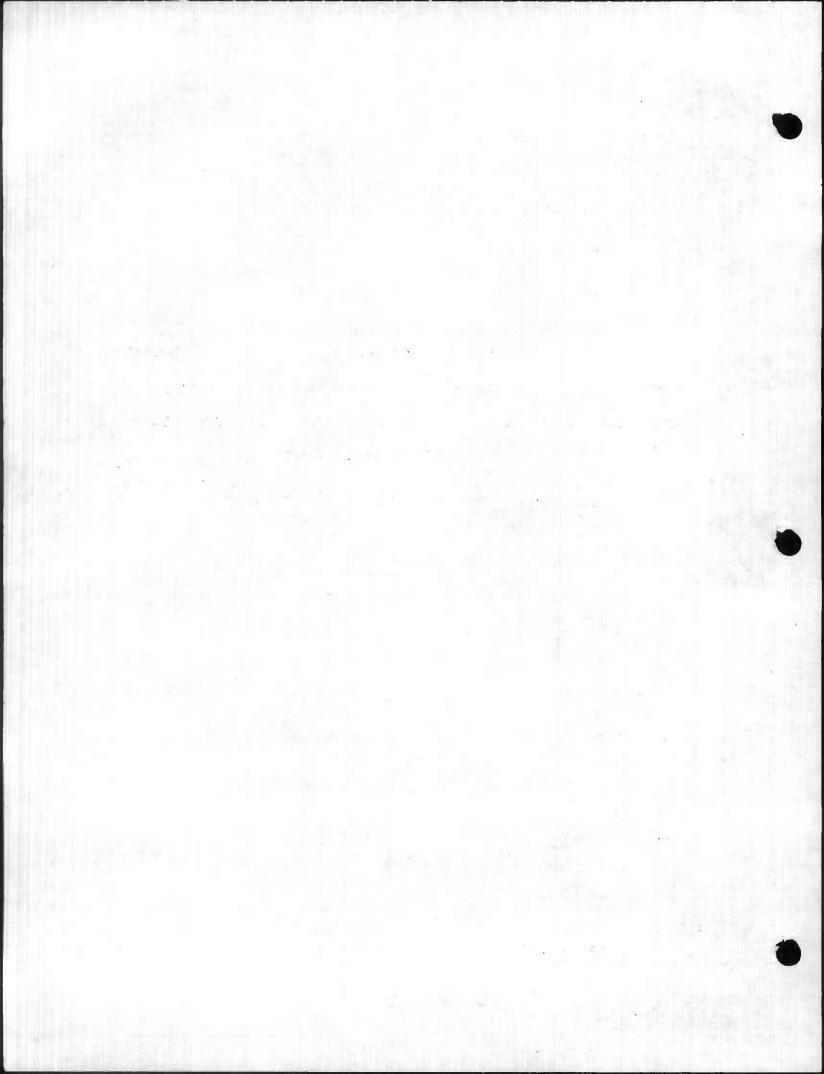
State of Maryland / Department of Health and Mental Hygiene	nn	26
Certificate of Death Reg. No.	00	20

			Certificate of	Death	Re	eg. No.	36283	
Physician	1. Decedent's Name (First, Middle, Last,				2. Dete of Deat Month November	12 ^{Pay} 2000	3. Time of Death	
/Medical Examiner	Frederick Yates Allen 4a Fecility Name (If not institution, give Augsburg Lutheran Home	street and number)		4b. City, Town, or Lo Baltimore	cation of Death	4c. County of		
Funeral Director	5. Social Security Number 6. Sec	7. Age (In yrs. Ia	st birthdey) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, August 13	,1922 B	9. Birthplaca (State or Foreign Country) altimore, Marylan	
the Maryland 28a-1 show notified at	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore		Town or Location keysville				10d. Inside City Limita 1 ☐ Yes 2 ☐ No	
after death with the Ma w ferma 23a ov 28a-f a never must be noutled Funeral Director	10e. Street and Number 10535 York Road Apt.1	.07	10f. Zip Code 21	1030		og. Citizen of Wh Inited Sta	tes of America	
filed within 72 hours after death with the Maryland Hygiene. Hygiene Hygiene Hygiene with the than "natural", or itema 23a or 28a-1 ahow ant, the Medical Examination must be notified at a Completed by Funeral Director	11. Merital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U,S Armed Forces? 1 ØYes 2 □ No If Yes, Give Year or Dates: W.W.II	. 13. Was Decedent of if Yes, specify Cut		pecify Yes or No- D Rican, etc.) 14. Race- Black, Specify:		- Americen Indian, , White, etc. White	
d within 72 hours aft glene. In than "natural", or , in the lead by F	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of working ed)	ing	16b. Kind of Busi		
permit. Pages 1 and 2 should be filed within 72 hours a Department of Health and Mental Hygiene. Timportant: If Item 27 is marked other than "natural", o any injury or other traumatic avent, me Medical Evan odica. To Be Completed by	12 17. Father's Name (First, Middle, Last) Frederick S. Allen	04	Accountant	18. Mother's Neme Ellen Yates		Auto Dea Maiden Sumeme,		
and 2 shoralth and N. 27 Is main	19a. Informant'a Name/Relationship (Ty Mary Elaine(nee Smith)		19b. Meiling Address (Stree 10535 York Road	Apt.107 Co	Route Number OCKEYSVIII	e, Maryla	nd 21030	
vermit. Pages 1 ar Department of Hea Important; if Itam in Injury or other	20a. Method of Disposition 1X Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	lemovet from State Dull an	ice of Disposition (Name of metery, cremetory or other pla ey Valley Memoria	al Gardens 11			ity or Town, State , Maryland	
Departimond Import any Ini	21. Signature of Funeral Service Licens	→ Jeffrey L. Gair	22. Name and Addr	ess of FacilityRuck 1050		neral Hom Towson, M		
Physician /Medical Examiner	23e. Park In the disease, or composition in the disease, or composition in the disease or condition resulting in death)	the caused the deeth.	Parkinso.	ing, such es cardiac d		est,	Approximate Interval Between Onset and Death	
ath certificate be executed strength and for use as the buriel-transit slan/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	as a consequence of): as a consequence of): as a consequence of):					
d by the setsched	Part II. Other significant conditions cor	itributing to death but not result	ting in the underlying ceuse g	iven in Pert I.	23b. Did to		ribute to the cause of death	
or Attending Physician: The law requires the after death. Director: After this cartificate has been signed in by the funeral director, page 2 should be de ertification: To Be Completed by F			3		24a. Was a perform		24b. Were autopsy findings available prior to completion of cause of death?	
					1	es 28No	1 Yes 2 No	
	25. Was case referred to medicel examiner?	lospitet:	R/Outpetient 3□ DOA Of	26. Place of Death			(Specify)	
ne Hospital or Attending Physical hours after death. The Funeral Director: After this pletely filled in by the funeral dedical Certification: To edical Certification: To	27. Manner of Death 1. DNetural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be determined	28a. Dete of Injury (Month, Dey Year) 28e. Place of Injury - At hon building, etc. (Specify)	ork? Yes 2 No	Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rurel Route Numb City or Town, State)				
To the Hospital of within 24 hours at To the Funeral Discompletely filled is Completely Celegial Celegia		sician: To the best of my know her: On the bests of examination and manner stated.						
To the vithin to the comp	29b. Signature and title of certifier	> -		se number 7 3 7 5 7 3	2		(Month, Day, Year)	
3-641	30. Name and address of person who co	1	23a) (Type, Print) St. Reiste	vstan , 1	S ON	1136		
State Registrar	31. Date filed (Month, Day, Year) NOV 1 5 2000	32. Registrar's Signatu	Ana V					



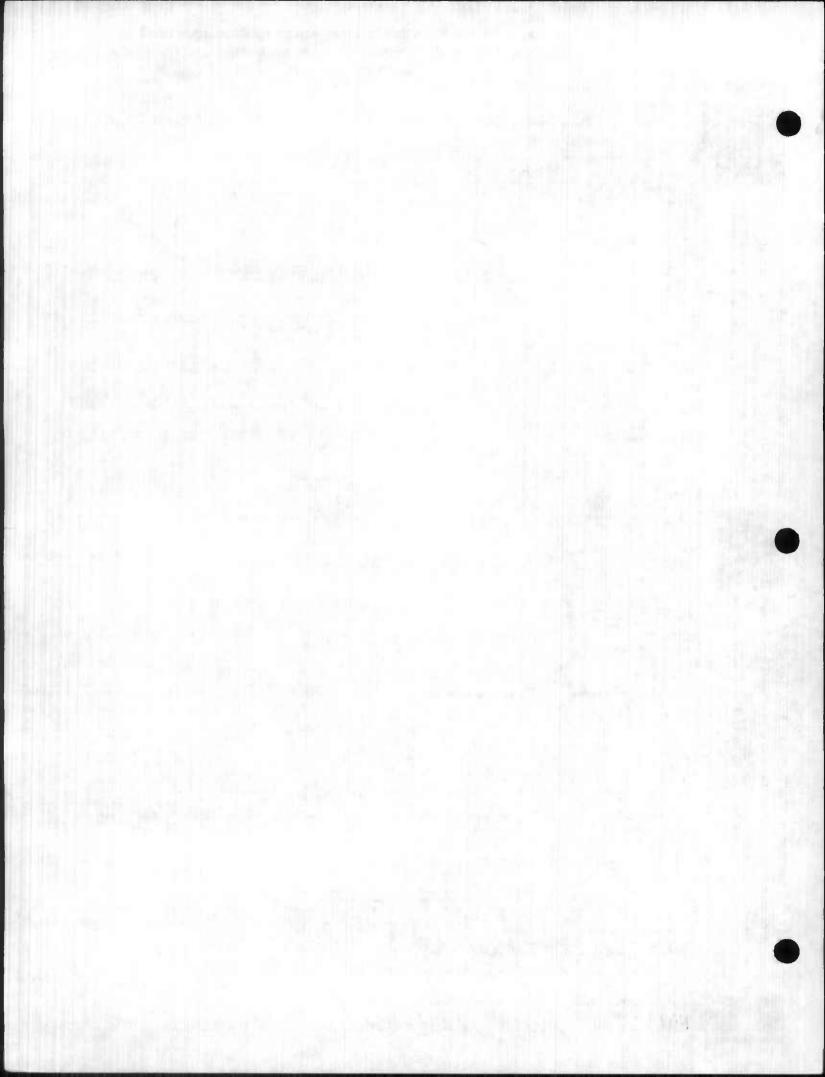
State of Maryland / Department of Health and Mental Hygiene Certificate of Death

								Death			Reg. No.	30	
- · ·	1. Decedent'a Nar	ma (First, Middle, La	ist)							2. Data of De	eath	Vaar	3. Time of Death
Physician /Medical	SAMUEL				AH	BRAMS				NOV.	12 Day 2	000	10:45AM
Examiner		(If not institution, gla ASSISTED			ESVILL	E		4b. City, To BALTI		ocation of Deat	th 4c. Count BALTI	y of Death	
uneral Director	5. Social Security 213–05–4	1832	Sex 1)X)M 2□F	7. Age (In yrs 85	last birthday Yrs.) If Unde Months	Days	If Undar Hours	24 Hrs. Min.	8. Data of Bi (Month, Di MAY 20	ay, Year)	9. Birthp Cour MI	placa (Stata or Foreigntry)
1	Usuat Rasidence			10c. C	ity, Town or L	ocation						1	Od. Inside City Limit
t or 28a-f sho be notified a Director	10a. Stata MD	BALTIMOF	Œ		ity, Town or L OWINGS								1 ☐ Yas 2X N
	10e. Street and N	ET VALLEY	COURT				p Code 2111	7			10g. Citizen of What Country? USA		
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death amend item 23a,b per md G789 11/15/00 vf Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 17, 2000 3:21 AM Ellwood L. Brown Sr /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 24 Hrs. 8 Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Yeer Months Days Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 1 M 2 ☐ F **Funeral** Days Yrs. Mar 25, 212-07-6945 82 MD Director Usuel Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 1 Tyes 2 No MD Rockville Montgomery Directo r than "natural", or thems 23s or 28s-the Medical Examiner must be notifi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural', or hems 23s or 9701 Veirs Drive 20850 Funeral USA 12. Was Decedent Ever in U,S. Apped Forces? 1 ≦ Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or Noff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: white p 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8 0 foreman 18. Mother's Name (First, Middle, Maiden Samame) 17. Father's Neme (First, Middle, Last) 2 should be to and Mental is is marked of Joseph E. F. Brown Pages 1 and 2 should nent of Health and Mer Annie O. Hurley 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ham 27 I Donna Weisner/daughter 1205 Dorchester Road Baltimore, MD 21207 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Department of important: If It any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 21. Signature of Fineral Service Lorentee Ronald S. Wade, Director 655 W. Baltimore Street 21201 Baltimore, MD Enter the disease, of complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Contineur **Examiner** Due to (or es e consequence of): Examine CHRONIC OBSTRUCTIVE LUNG DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): Box 68760. attending physician The law requires that the death certificate be Physician/Medical Due to (or as e consequence of) Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? P.O. Obstructive signed by 1 | Yea 2 | No 3 | Probably 4 | Unknown Division of Vital Records, þ umollorAx 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed PREVIOUS page 2 STROK 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 € No Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Dinpatient 2 ER/Outpatient 3 DOA P this 28e. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: After or Attending 5 Pending investigation 1 CNatural ours after death. eral Director: Aft filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be 3 Suicide 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C completely filled To the Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. edicai 29e. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier leted cause of death (Item 23a) (Type, Print) 30. Name and address of person who complete Fernald Ra BARTY eVIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar acres.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death 32 Verna Butler November 14,2000 4a Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death saltimore N/A 405pital Maryland If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth Jun 8, 1946 5. Social Security Number 7. Age (In yrs. lest birthdey) 6. Sex 1 M 2 F Birthplace (State or Foreign Country) 54 Yrs. Months Deys Hours MD 21844-3476 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 Yes 2 No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21205 2613 East Monument Street 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritel Stetus 1 Never Married 2 Merried 1 Tes 2 No Specify STACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hospital Elementary/Secondary (0-12) College (1-4or 5+) Orderley 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Minnie Penn Ferris Butler 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2613 East Monument Street Baltimore, Md 21205 Delores Butler-Wife 20b. Plece of Disposition (Name of cametery, cremetory or other pleca) 20c. Location - City or Town, State Nov 15 Baltimore, 2000 Metro Crematory 4 Donation 5 Other (Speedy) 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Waters Funeral Service 1216 East Federal Street Baltimore, MD lenes alles 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset and Deeth Preumona Immediate Cause (Final disease or condition resulting in death) Due to (or es a consequenca of tor Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last 10 Due to (or es e consequenca of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? 20 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medicaf 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

permit. Pages 1 and 2.
Department of Health as Important: if Item 27 le eny Injury or other treu page.

Physician

/Medical

Examiner

Funeral

Director

28a-f show

?7 is marked other than "naturel", or items 23a or treumstic event, me Medical Examinar must be re

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

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Funeral

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Completed

Physician/Medical Examiner 2 should be detac Be Completed by paged

After this cartificate has tha

Box 68760, P.O. Certification: To

Records, Division of Vital Hospital or Attending Physician: s after death. in by

Butter, Vernon

To the Hospital of the Funeral Completely filled

State Registrar

Medicai

27. Manner of Death

1 Neturel

2 Accident

3 Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

5 Pending investigation

6 Could not be

MD

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

Injury at Work?

1 Yes 2 No

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end placa, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 100

16:50 Am

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

28d. Describe how injury occurred

30. Name and address of parson who completed cause of death (Item 23a) (Typa, Print)

90 Rhoades miD. Mary land aN

31. Date filed (Month, Day, Year) 32. Registrer's Signeture

DHMH 16 Rev 6/95

ORIGINAL

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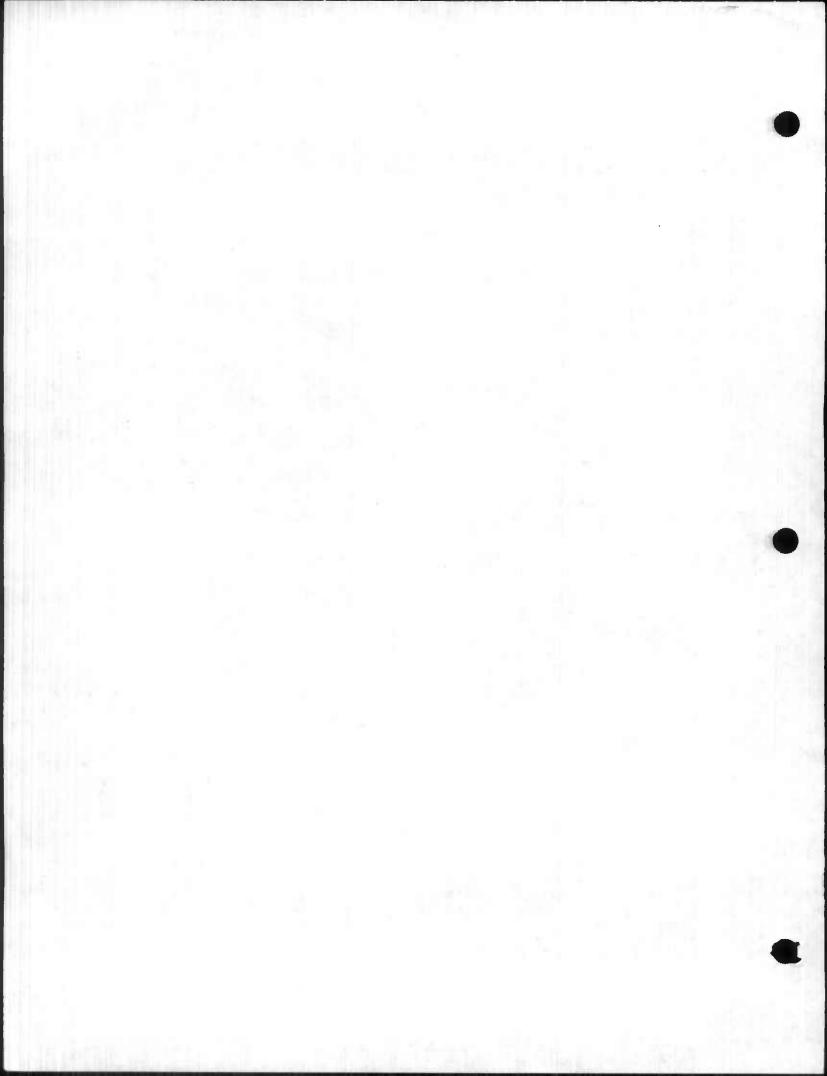
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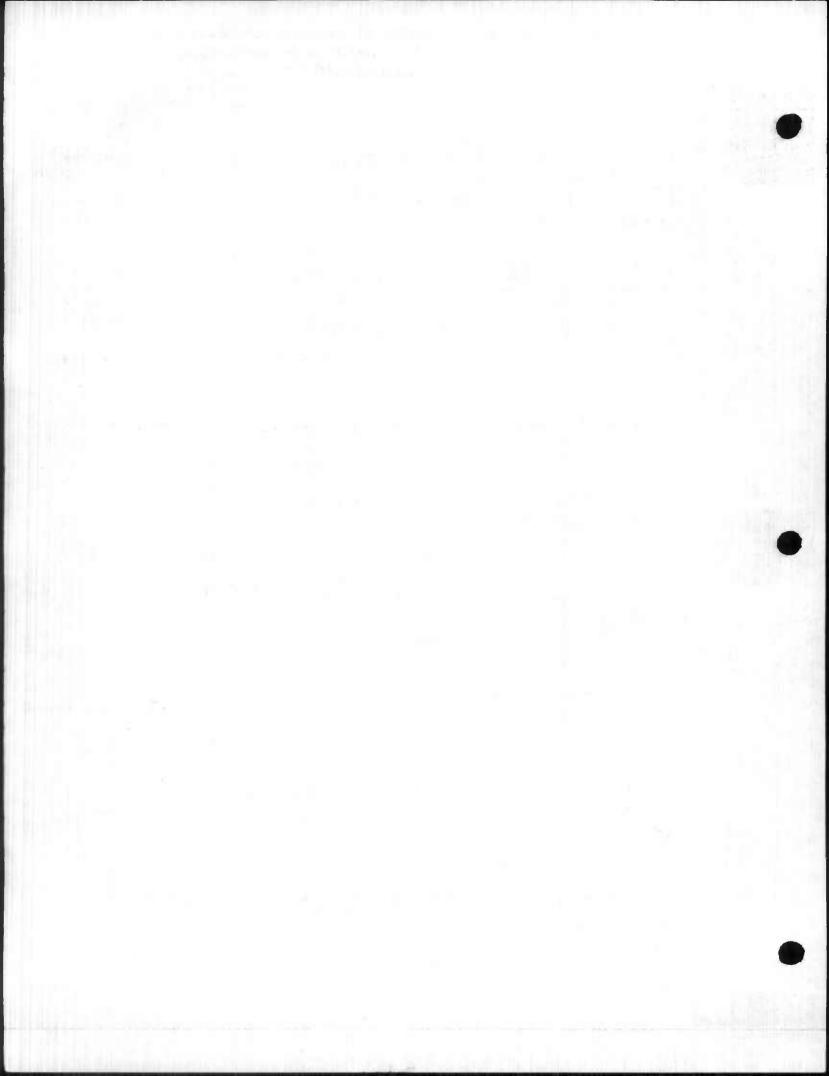
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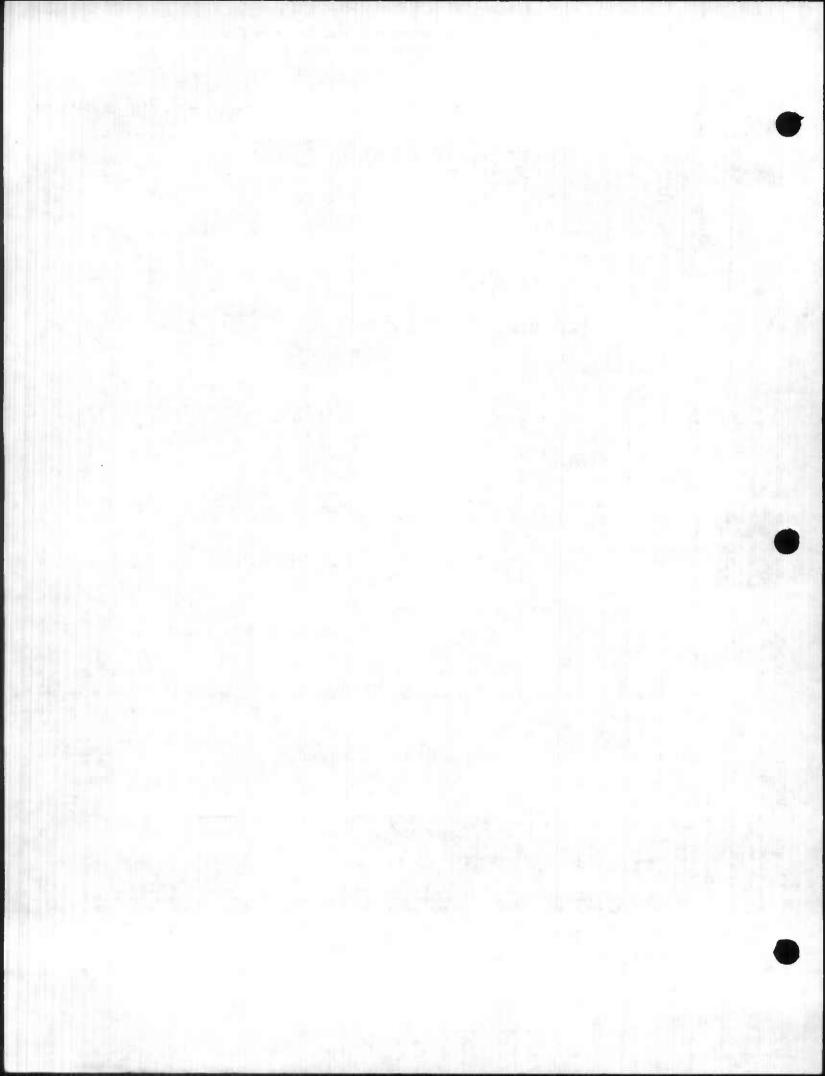
32. Registrer's Signature



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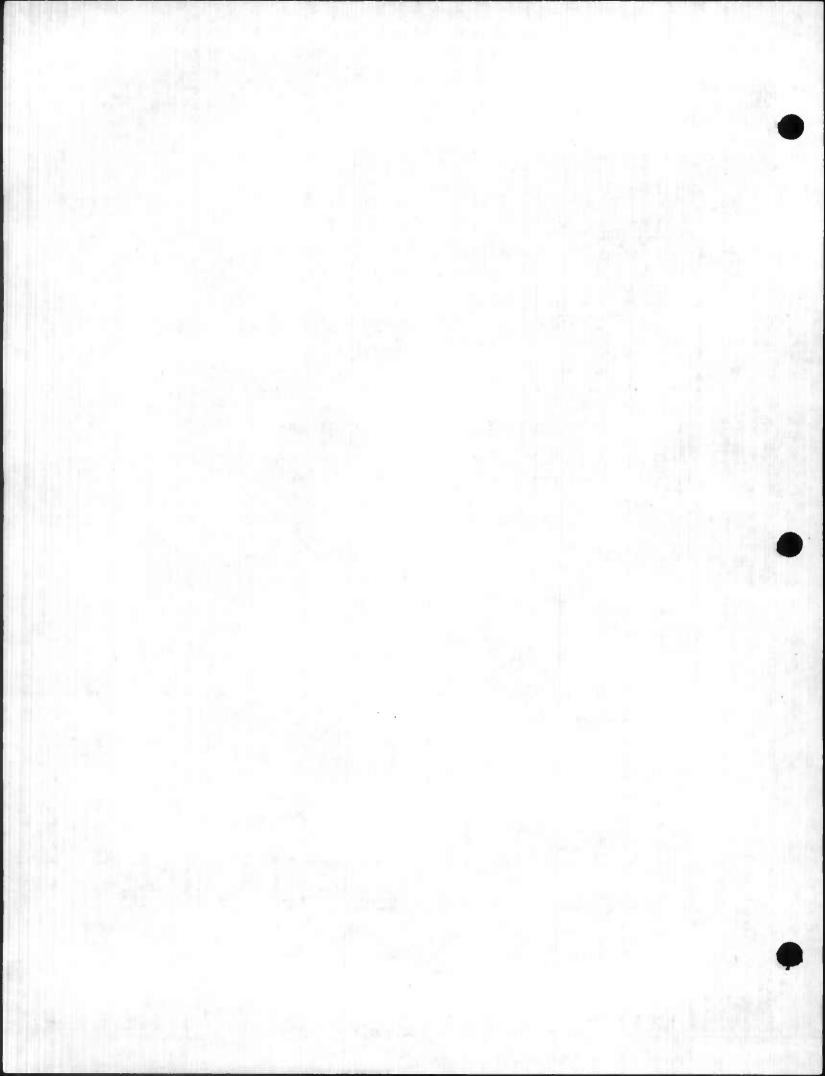
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Neme (First, Middle, Last) 2. Date of Death 13, 2000 Month **Physician** 5:40 p.m. Carleta Mae Barr November /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Wesley Home Baltimore If Under 24 Hra. 8. Dete of Birth (Month, Dey, Year) May 16, 19 5. Sociel Security Number 7. Age (In vrs. last birthday) If Under 1 Yeer Birthplaca (State or Foreign Country) **Funeral** Deys 1 M 2 KF Montha 80 222-09-8864 New Jersey Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a Stete 10b. County 10c. City, Town or Location 1 X Yes 2 □ No Directo Maryland N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23s or 21209 2211 Rodgers Avenue United States Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yea 2 ऒ No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 11: Meritel Statue Pages 1 and 2 should be filed within 72 hours after cand of Health and Meriel by Upiece.

Int: If florm 27 is marked other than "natural; or flee inty or other traumatic event, ins. Health and the interior of the traumatic event, ins. Health and the interior of the traumatic event, ins. 1 ☐ Never Merried 2 ☐ Merried Baitimore, Maryland 21215-0036 1 Yes 2 No Specify: g 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Assistant Manager Banking 12 yrs. 18. Mother's Neme (First, Middle, Malden Sumeme) 17. Father's Neme (First, Middle, Last) Be Philip Viven Maude Swain 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD Mrs. Carolyn B. Orofino /Daughter 3107 Moreland Avenue 20b. Plece of Disposition (Neme of cametery, cremetory or other pleca) Dete 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) Entonoment permit. Page Department of Important: If any Injury or pnce. Dulaney Valley Mem. Gardens 11/17/00 Timonium, Maryland 21. Signeture of Funeral Service Licensee Michael E. Canapp 22. Name and Address of Fecility 5305 Harford Road LEONARD J. RUCK, INC. Baltimore, MD 21214 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete tntervel Between Onset and Death **Physician** A Thero Servita Vasallen Diseare /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner physician and s the burial-trans Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of) USB Pert II. Other algniftcant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contributs to the cause of death? Coroney Anten Disease 1 Yaa 2 No 3 Probably 4 Unknown Consetne Heart failne à 24b. Were autopsy findings available prior to 24e. Wes en eutopsy performed? Completed completion of cause of death? certificate has b 2 12 No 1 Yes 2D No 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA To Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 27. Menner of Death 28c. Injury at Work? After 1 Deletural or Attending 5 Pending investigation 1 Yes 2 No death. 2 Accident after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 T Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 14100 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) LIBERB, MO. 3108 BANK ST BALTO, need 21224 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State MOV 1 5 2000 Registrar

DHMH 16 Ray 6/95



Please Type or Print in Black indelible lnk. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month Marjorie C. Berlitz November 12 2000 12:00 pm 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 24 Hrs. If Under 1 Year 8. Dete of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Months Hours Davs 88 23, 1912 Ohio Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Anne Arundel Tracys Landing 10f. Zip Code 10g. Citizen of Whet Country? 6333 Genoa Road 20779 HSA 14. Rece - American Indian, Was Dacedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) Bleck, While, etc. ☐ Yas 2X No Yes. Give 1 Never Merried 2 Merried 1 ☐ Yes 20XNo Specify: White Specify If Yes, Give Yeer or Dates: 3 Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantery/Secondary (0-12) College (1-4or 5+) Power Company Secretary 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) George L. Conner, Sr. Theresa Wagenman 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Coda) 19e. Informent's Neme/Raletionship (Type, Print) Daniel P. Buck (Personal Rep.) 10726 Lakespring Way, Cockeysville, MD 21030 20b. Place of Disposition (Name of cametery, cremetory or other place) Dete 20c. Location - City or Town, State 11/16 1 2 Burial 2 ☐ Crametion 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Cemetery 2000 Annapolis, MD 21. Signature of Funerel Service Ligensee 22. Name end Address of Facility
Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

then "natural", or items 23s or 28s-t show the Medical Exerciper must be notified at

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filed within Hygiene.

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permit. Pages 1 and 2 should be 3 pertment of Health and Mental 3 reportant; if Item 27 te marked of

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Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Records,

Division of Vital

5. Sociel Security Number

10e. Street and Number

20e. Method of Disposition

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11 Mental Status

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Funeral

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Examiner

attending physician and for use as the burial-transit The law requires that the death certificate be executed Physician/Medical ed by the a signed by by been si Completed page 2 s certificate Physician: director Be 10 this funeral Certification: After t or Attending death. Director: A after To the Hospital o within 24 hours aff To the Funeral DI completely filled in edical

Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, or heart failure/List only one ceuse on sech line. Immediate Cause (Final disease or condition resulting In deeth) BUELDING CASTROINTESTINA Due to (or as e consequence of) 5 MPHYSEM A Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events rasuiting in deeth) Last Dua to (or as a consequence of) Due to (or es a consequance of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. DEMENTIA

23h. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24e. Wes en eutopsy performed?

2 2 NO 1 Yas

24b. Were eutopsy tindings aveilable prior to completion of cause of death? 1 ☐ Yas 2 ☐ No

Approximate tntervel Batween Onset and Deeth

25. Wes case reterred to medicel examinar? 26. Placa of Death (Check only one) Hospitel: 1 npatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yas 2 10 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 27. Mannar of Death Neturel 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 ☐ Suicida 28e. Plece of Injury - At home, ferm, streat, fectory, office building, atc. (Specify) 4 | Homicide

29a. Certifiar 1DXCertifying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, end due to the causa(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the causa(s) and mannar stated. (Check only one)

29b. Signeture and title of certifian

31. Date filed (Month, Day, Year)

NOV

5 2000

29c. Licensa number D39037 29d. Data signad (Month, Day, Year)

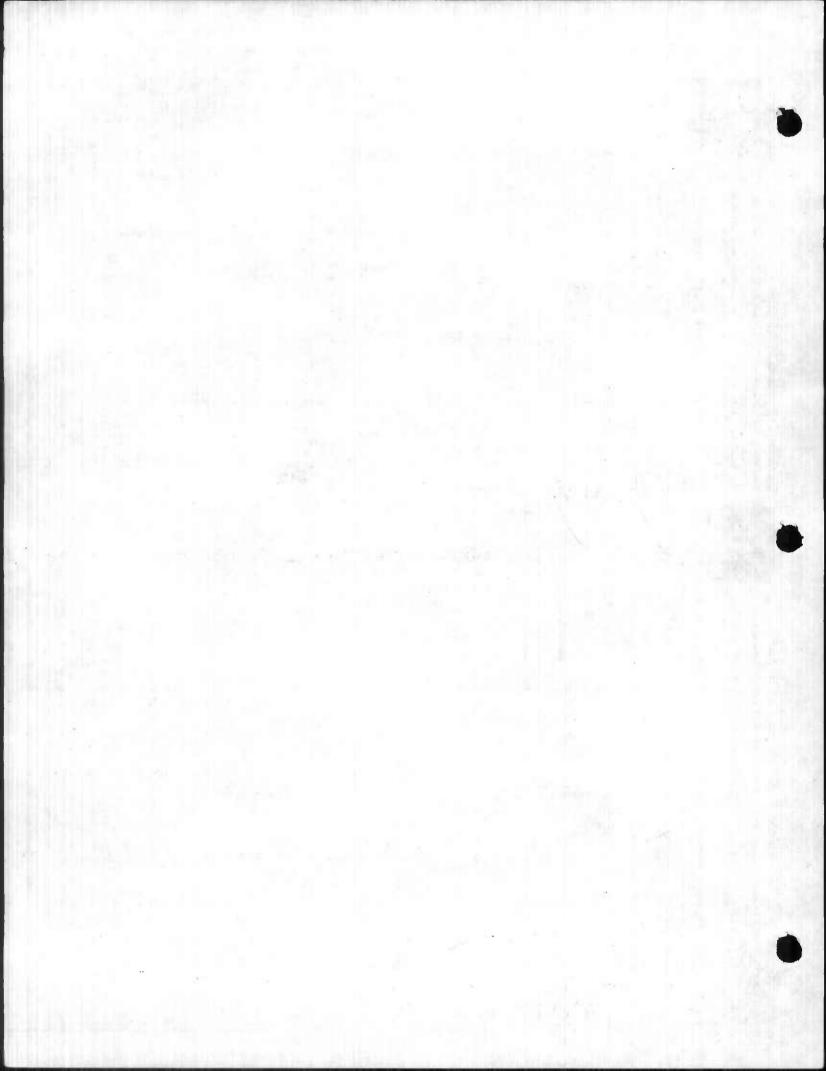
30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)

DOUGLAS S MITCHELL AAMC

32. Registrer's Signature

ANNAPOUS

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Yee Month Day **Physician** William J. Comegys 2000 13, Nov. 6:13am /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner 1316 McHenry Baltimore Street NA Birthplace (State or Foreign Country) If Under 1 Year Dete of Birth (Month, Day, Year) 03-05-47 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Deys Hours Months XXM 2DF Yrs MD Director 218-46-6891 Usual Residence of Decedent 10b. County 10e Stete 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or itema 23a or 28a-f show trsumatic event, the Medical Examinet must be notified at X Yes 2□ No Director MD NA Baltimore 10e. Street and Number 10f. Zio Code 10c. Citizen of What Country? 1316 McHenry Street 21223 USA Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Rece - American Indien, 11. Meritel Stetus Bleck. White, etc. 1 Yes 2 No 1 ☐ Never Merried 2 ☑ Merried 1 Yes 2 No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced Black Year or Dates: Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) nd Mental Hygiene. marked other than Elementery/Secondary (0-12) College (1-4or 5+) Janitorial Keswick Nursing 10th Grade 17 Father's Name /First Middle Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if flem 27 is marked ofth eny Injury or other traumatic event appea. Doris William Comegys Hatcher 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21223 Christine Comegys 1316 McHenry Street Baltimore, Maryland 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete x☐Burial 2 ☐ Cremetion 3 ☐ Removel from State Pk. Cem. 11-17-2000 Arbutus, 4 ☐ Donetion 5 ☐ Other (Specify) Arbutus Mem. 22. Neme end Address of Facility 21. Signature of Funeral Service Licensee Baltimore, Maryland 21202 fre WM.C.March FH 1101 E. North Avenue to 23a. Part1. Enter the diseese, or com shock, or heert feilure. List only on the use the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, Approximete Interval Between Onset and Deeth **Physician** tmmediate Cause (Final disease or condition resulting in deeth) /Medical Months Examiner Due to (or as a consequence of) Examiner physician and the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Physician/Medical Due to (or as e consequence of): stending p 950 23b. Did tobacco use contribute to the cause of death? ed by the s Pert II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by t 3 Probably 4 Unknown 1 Yes 20 No à 24b. Were autopsy findings evailable prior to should 24a. Wes an eutopsy performed? Completed completion of cause of deeth? page 2 s has 2 No 2 No 1 Tyes certificata 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) tnjury at 28d. Describe how injury occurred Hospitel: 1 Yes 20 No To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. tnjury at Work? Certification: After 5 Pending Investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No I Director: / 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 HomicIde 24 hours after Funeral Directions Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. edicai 29a. Certifie (Check only one) To the complete 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe

State Registrar

DHMH 16 Bay 6/95

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filed within 72 hours after

The law requires that the deeth certificate be executed

Physician:

Hospital or Attending

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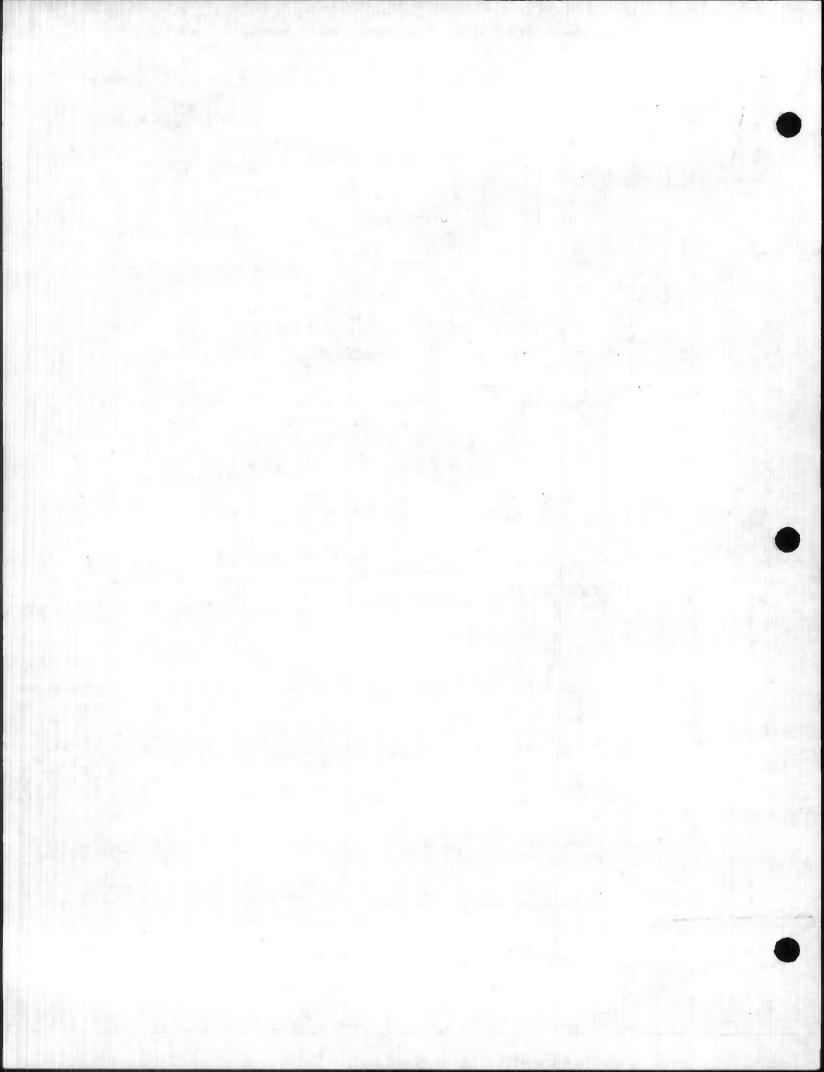
Division of Vital Records, P.O. Box 68760.

altimore, Maryland 21215-0036

31. Date filed (Month, Day, Year) 2000 32. Registrer's Signeture

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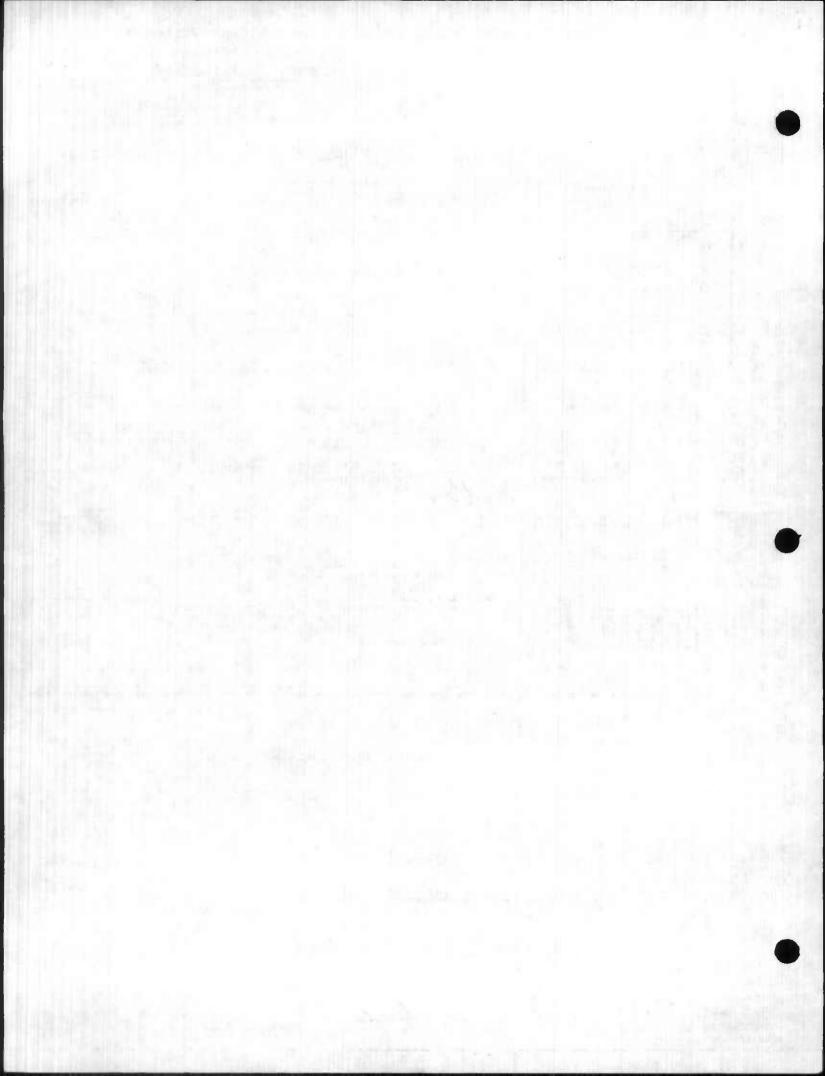
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)



State of Maryland / Department of Health and Mental Hygiene 00 36293

Certificate of Death Reg. No.

			Cer	titicate (of Death		Reg	J. No.		0 2 3
ician	1. Decedent's Name (First, Middle, Last) IRENE CREEK						te of Death onth	Day 20	Year 000	3. Tima of 0
dical niner	4a Facility Name (If not institution, give street and	number)			4b. City, Tow	m, or Location		4c. County		
	UNIVERSITY OF MD MEI	DICAL SYS	STEM			IMORE		N/A		
r	5. Social Security Number 6. Sex 1 日 M 2項1	7. Age (In yrs. las	Yrs.	If Under 1 Y Months Di	ear If Under 2 ays Hours		te of Birth onth, Pay, 1 Y 16,	1905	9. Birthpla Countr	ce (State or MD
	Usual Residence of Decedent 10a. State 10b, County	10c. City,	Town or Loc	cation					100	d. Inside City
50	MD N/A		LTIMO							1X Yes
Director	10e. Street and Number	DAI	U11111C	10f. Zip Co	de		100	g. Citizen of V	√hat Countr	v?
	1425 WARD STREET			2123				U.S.		
Funeral	11. Marital Status 12. Was D	Decedent Ever in U,S.	13. W		of Hispanic Orlg Cuban, Mexican,	in? (Specify Y	es or No-	14. Rac	- America	
þ	1 Never Married 2 Married 1 Yes,	Forces? Sive Or Dates:		Yes, specity		Риепо нісап,	etc.)		k, White, et BLAC	
Completed	15. Decedent's Education (Specify only highest grade complete		16a. Deced	ent's Usual O	ccupation	of working	10	6b. Kind of Bu	siness/Indu	stry
uple		e (1-4or 5+)	life. D	O NOT use re	one during most etired)	Or Working				
Com	12 0		DOME	ESTIC				DOMES		
89	17. Father's Name (First, Middle, Last)					's Name (First			Θ)	
2	JAMES CREEK					IZABE				
	19a. Informant's Name/Relationship (Type, Print)				reet end Number					
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H	1 XBurial 2 Cremation 3 Removal fro 4 Donation 5 Other (Specify)	om State _ cerr	NATL.	CEM.	place)	9-2000		AUREL	MD	
	21. Signature of Funeral Service Licensee EUGENE WALKER	de Jalls			ddress of Facility				ERAL 2121	
	23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of	at caused the death. in each line.	Do not ente	er the mode of	dying, such as c	cardiac or resp	iratory arres	st,	. 1	Approximate interval Betw Onset and D
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	resulting in death) a.	Due to (or a								
Examiner		DNEII	MONIA						1	O DAY
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Medicai	resulting in death) Last	Due to (or a	s a consequ	uence of):						
by Physician/	Part If. Other significant conditions contributing to	o death but not reculti	ing in the un	deriving cause	a given in Bart I		3h Did toh	acco uee co	ntribute to	the cause o
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mo							1 ☐ Yes	2 DXNo	10	Yes 20
Be C	25. Was case referred to medical			-	26. Place	of Death (Che	ck only one)		
TOE	examiner? Hospital: 1	☐ Inpatient 2 Ef	R/Outpatient	t 3□ DOA	Other: 4 Nur	rsing Home	Residen	nce 6 □Oth	er (Specify))
	27. Manner of Death Natural 5 □ Pending 28a. Da (N	ate of Injury 2 Month, Dey Year)	8b. Time of fnjury	28c.	Injury at Work?	28d. D	escribe how	w injury occur	ber	
Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Pl	aca of Injury - At hom uilding, etc. (Specify)		M eet, factory, of	1 ☐ Yes 2 ☐ N	28f. Lo	ocation (Stri ity or Town,	eet and Numb State)	er or Rurel	Route Numi
Ö	29a. Certifier 1 XCertifying Physician: To (Check only one) Medical Examiner: On the and or one)	the best of my knowle e basis of examination	edge, death n and/or inv	occurred at threstigation, in	ne time, date end my opinion, deati	d place, and du h occurred at t	e to the car he time, da	use(s) and ma te and placa,	nner as sta	ited. the cause(s)
20		TETHIOI STATEG.					1 00	d Data siana	d (Manth F	lev Year)
Medicai	29b. Signature and title of certifier			29c. Li	cense number		29	d. Date signe	a (Month, L	wy, roury
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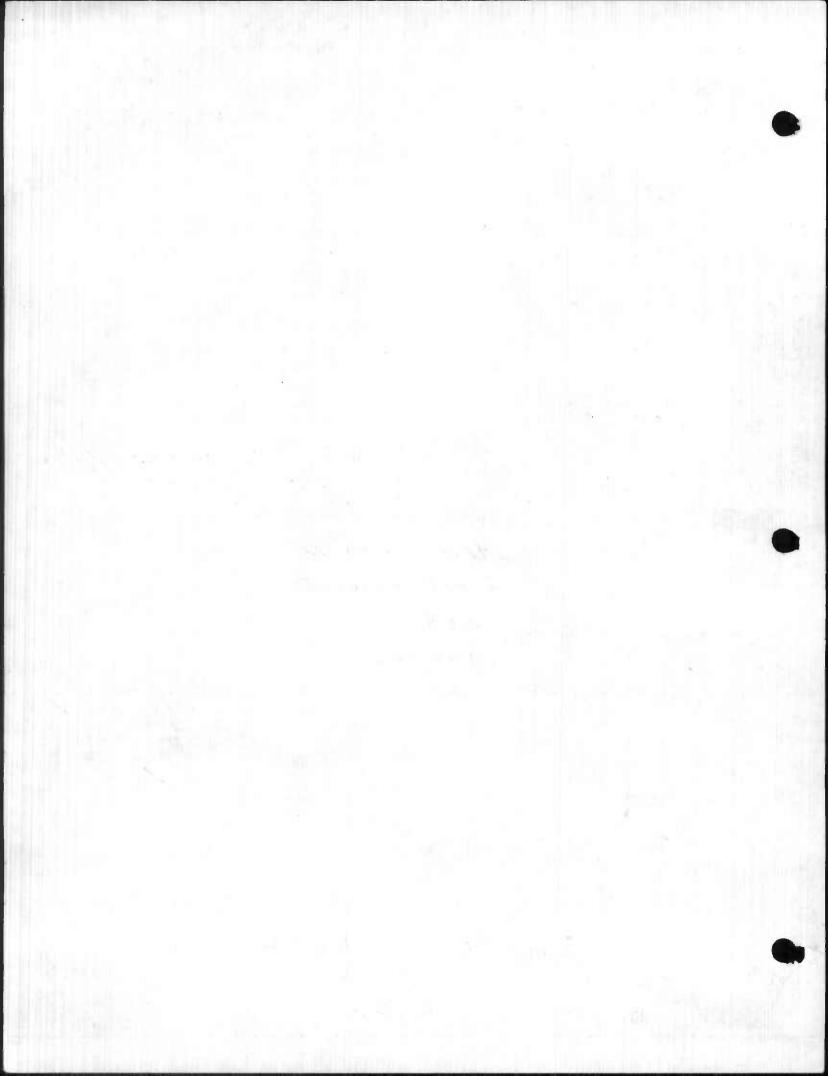
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			State of Maryla	-	rtificate of			Reg. No.	0 36294
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faryland show	or	Usuat Residence of Decedent 10a. Stete 10b. County MD N/A		City, Town or L					10d. Inside City Limits 11 Yes 2 □ No
vith the h	Director	10e. Street and Number		342011	10f. Zip Code			10g. Citizen of W	het Country?
5-0020 72 hours after death with the Maryland natural", or Hema 23a or 28s-f show	by Funeral	836 Whitmore 7 11. Meritel Status 1 Never Married 2 Married 304 Midowed 4 Divorced	AVENUE 12. Wes Decedent Ever in Armed Forcas? 1 ☐ Yas 34310 ff Yes, Give Yaer or Dates:	U,S. 13.	2121 Was Decedent of If Yes, specify Cub 1□ Yes 2⊠No	Hispanic Origin? (S pan, Maxican, Puan	pecify Yas or No o Rican, atc.)		- American Indian, , Whita, etc. BLACK
vithin within the second	Completed t	15. Decedent's Ed (Specify only highest grad Elementary/Secondery (0-12)	ucation	(Give	dent's Usuel Occu e kind of work done DO NOT use retire	during most of wo	rking	16b. Kind of Bus	
Maryland 2 d 2 should be filed th and Mental Hygin 7 Is marked other traumatic avent, it	To Be C	17. Father's Neme (First, Middle, Last) Andrew L. Roll	lins		me nake			Meiden Sumeme	
	-	19a. Informent's Neme/Reletionship (7) Bernadette Co.	ype, Print) Leman	836		re Ave.	,Balto,	MD 212	16
0 8027		20e. Method of Disposition 1 ⊠ Buriel 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify)	Removel from Stata	cometery, cre	ore Nat	ional C		/17 Ba	lto, MD
Baltimoperation Page Department Important: Important: any Injury o once.		21. Signature of Funaral Sarvice Licens	rutter		2. Name end Addr 2501 Gw	74.	utter H lls Pkv	Suneral vy.,Bal	Home Inc. to.MD 21216
Physician /Medical Examiner	ner	23a. Pert1 Enter the disease, or comp shock, or heert fellure. List only of Immediate Cause (Finel disease or condition resulting in death)	e. Luly	Faul (or es e conse	lure	ing, such as cardia	c or respiratory a	rrast,	Approximate Intervel Between Onset and Deeth
6876(ficate be physicia is the but	/Medical Examiner	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	. depatit	(or as a conse	2				
O. Box (e death certif	Physician/M	Pert ii. Other algnificant conditions co	entributing to death but not n	esulting in the	underlying cause g	ivan in Part I.	23b. Did	tobacco usa con	tributa to the cause of death?
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Records,	Completed							an autopsy ormed?	24b. Were autopsy findings available prior to completion of cause of death?
	o Be	25. Wes case referred to medical axaminer?	Hospitel: 1 ☐ Inpatient 2	☐ ER/Outpatie	ent 3 DOA	ther:	eth (Check only		1 Yes 2 No MARIS AT WEACY IN (Specify) HOSDICE
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95.50	al Certif		28e. Plece of Injury - Al building, etc. (Spe	cify) nowledge, dee	th occurred at the t	ime, date and place	City or To	wn, Stete) ceuse(s) and ma	nner as stated.
2524	Medical	(Check only 2 Medical Examone) 29b. Signature and fitte of optifier	iner: On the basis of exami and manner steted.	nation and/or i		opinion, deeth occi	urred at the tima,		Ind due to the cause(s) (Month, Day, Year)
		· On hy	~			4085			ber 14, 2000
BU.C		30. Name and address of person who can be addressed by the can be address	R9. 30	1 51	PAUL	PI	BAlti	MORE	Md 21202
Stat		31. Date filed (Month, Day Year)	2. Registrer's Sig	neture	book	/			

DHMH 16 Rav 6/95

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iner I r	5. So 21	cial Security Number 6.5 9-32-6781 Il Residence of Decedent	DER CA	RE Co (In yrs. las	Month	Mor ler 1 Year	Ab. City, Town, or BALT If Under 24 Hrs. Hours Min.	8. Dete of Bi	rth	9. Birth	oplece (State or Foreign intry) yland
	_	Stele 10b. County		10c. City, 1	Fown or Location						10d. Inside City Limita 1 ☐ Yes 2 ☐ No
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		15. Decedent'a E (Specify only highest gri	ducation ade completed)		16a. Decedent's Us (Give kind of a	vork done	ation during most of wor	king	16b. Kind of	Businass/II	ndustry
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		Allen Coates Informant's Neme/Reletionship	(Time Print)		19b. Meiling Addre	nee (Ctrast		Griffin		em State 7	in Code)
		arbara Davis/da			102 Berl	in Av	venue, Ba	11timore	, Mary	land 2	21225
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				ıt not resulti	ng in the underlying	cause giv	ren in Pert I.		l tobacco use		to the cause of death?
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	Pert	I. Other significant conditions (contributing to death bu					24a. Wa	s an autopsy ormed?	0	Vere autopsy findings vallable prior to completion of cause of death?
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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Eleanor Jane Leitch Collison November 6 2000 2222 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov. 26, 1914 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M XXF 85 Yrs Maryland 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Edgewater 10g. Citizen of What Country? 10f. Zip Code 21037 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 ☐ Yes 2 No Specify: Specify: Year or Dates:

Funeral Py

Director

with the Maryland raff, or items 23s or 28s-f shorexist and examiner must be notified at death v naturaf the Medical I Hygiene. Pages 1 and 2 should be filed w ment of Health and Mental Hygie lant: If Nem 27 Is marked other the lury or other traumatic event, Its permit. Page Department of Important: If any injury or once.

Baitimore, Maryland 21215-0036

Physician

/Medical

Examiner

Funeral

Director

ahow

Physician /Medical Examiner

physician and the burial-transit 60 980 ed by the a been si page 2 certificate has this funeral After 5

Box 68760. o. Records, Division of Vital after death. ò 24 hours To the Hosp within 24 ho To the Fune completely fi

Completed 12 Be Examiner Physician/Medical þ Completed Be 10 Certification: 2 Accident 3 ☐ Suicide 4 Homicide

217-56-3954 Usual Residence of Decedent 10b. County Anne Arundel 10e. Street and Number 504 Mayo Road 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Preston Dudley Leitch Edith Irene Kirby 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas E. Collison IV/Son 650 Hillmeade Road, Edgewater, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 □ Ronation 5 □ Other (Specify) 11/9/00 Hope Chapel Cemetery Mayo, Maryland ns of Funeral Service Licenses 22. Name end Address of Facility Hardesty Funeral Home, P.A. am 12 Ridgely Avenue, Annapolis, Maryland 21401 of or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA disease or condition resulting in death) Ony Due to (or as a consequence of): EHYDRATION DAY Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in death) Last Due to (or as a consequenca of): ACUTE MOCARDIAL Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. DEMENT (A

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes No 26. Placa of Deeth (Check only one)

28d. Describe how injury occurred

1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year) 28b. Time of 28e. Ptaca of trijury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b, Signature and little of earlifer

DSM ITCH ELL

29c. License number

29d. Date signed (Month, Day, Year) Q

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospitel:

AAMC 64 31. Date filed (Month, Day, Year) NOV 1 5 2000

FRANKLINIST 32, Registrar's Sinnature

ANNAPOLIS, MI

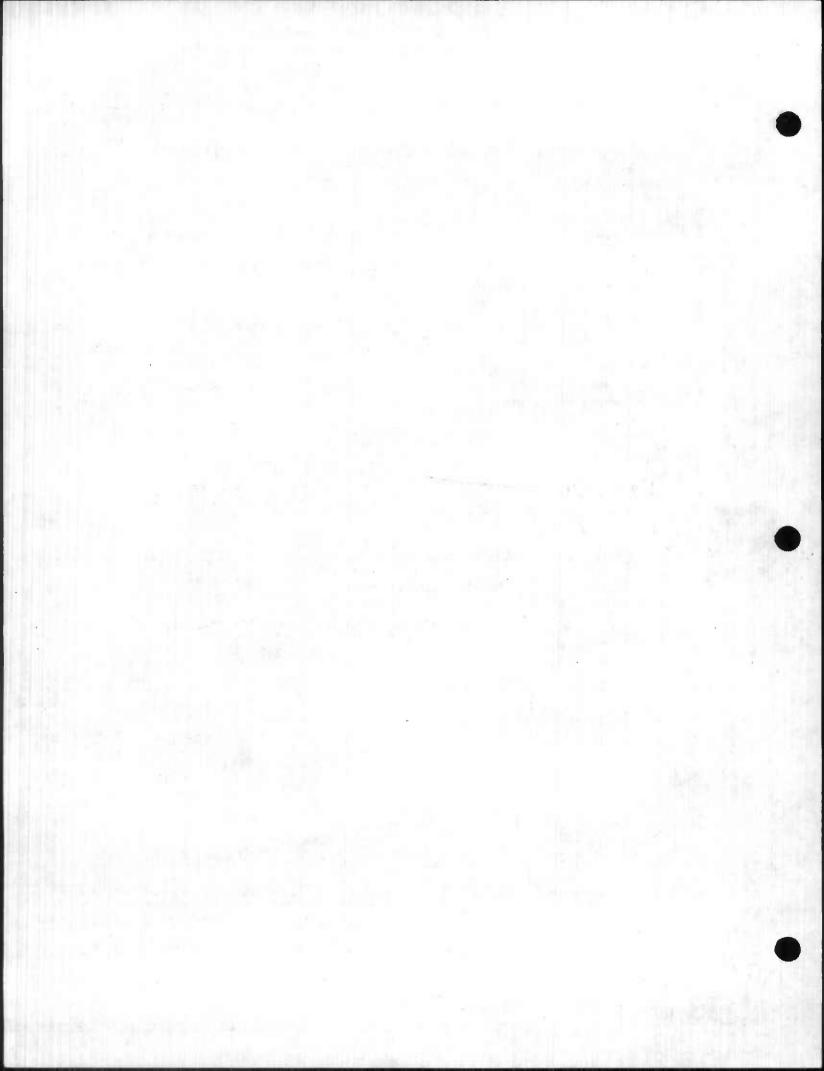
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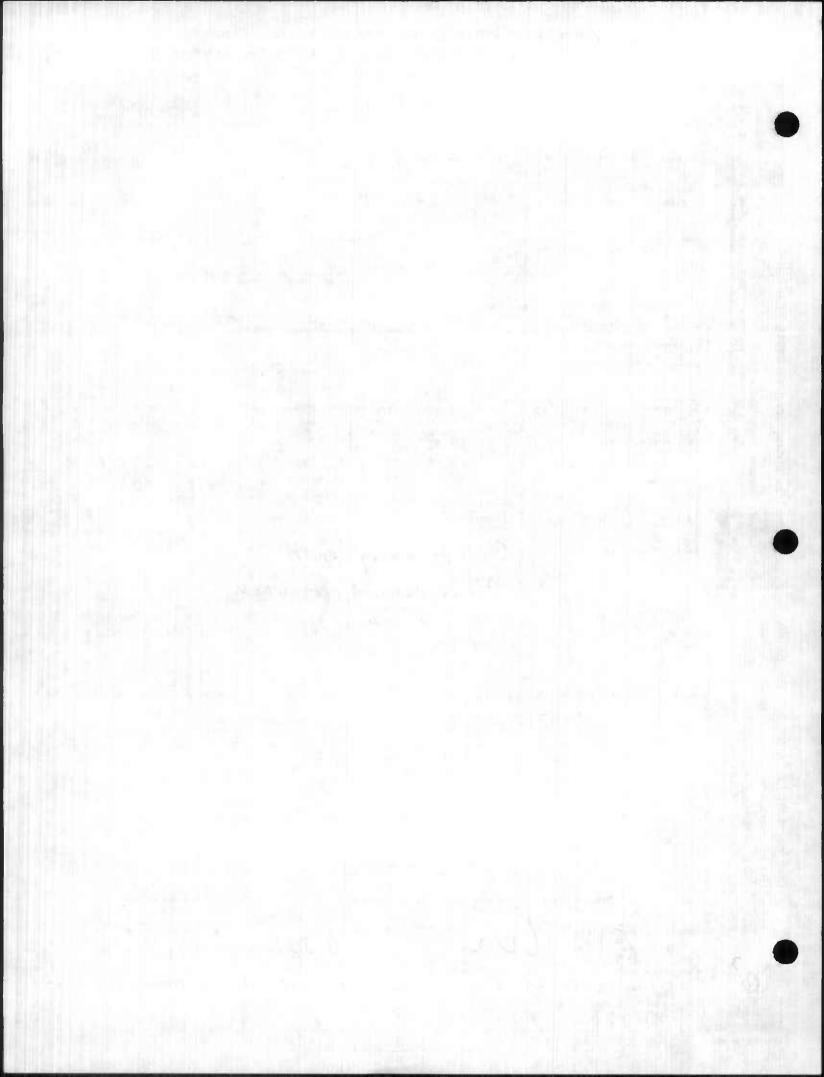
29a. Certifier

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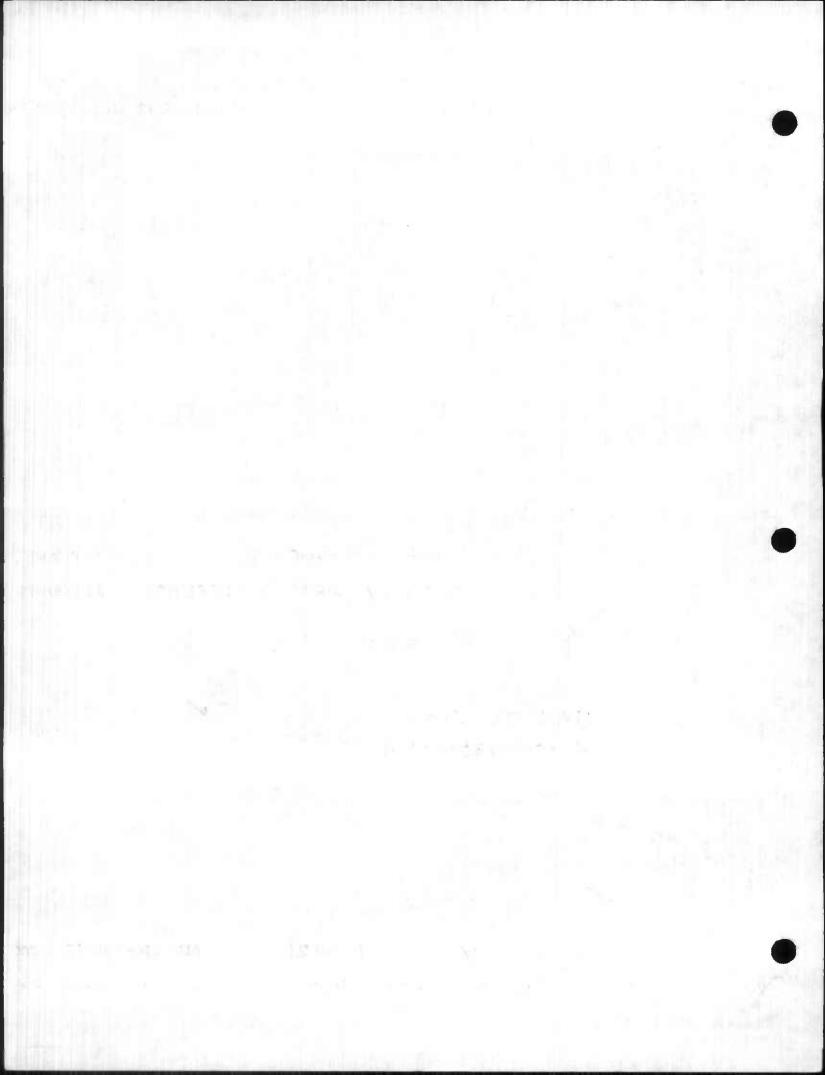
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			Ce	rtificate	e of	Death		F	leg. No.		
Physician	Decedent's Nama (First, Middla, Las REBA)	CI	HARLO)W			2. Data of Dea Month NOVEMB		S O O O O	3. Tima of Death 11:00 am
/Medical Examiner	4e Facility Name (If not institution, giva	SUMMA DESCRIPTION				4b. City, Tow	vn, or Lo	cation of Death	4c. County		22.00 am
25.5	4420 EVAMAY ROA			If Under	1 Vaar	BALTI					N/A
Funeral Director	214-01-0302	7. Age (In yrs. 95	Yrs.	Months	Days	Hours	Min.	8. Data of Birth (Month, Day APR - 22	1905	9. Birthp Coun	lace (Stata or Foraign itry) MD
9 Bu	Usuel Rasidence of Dacedant 10a. Stata 10b. County	10c. Ci	ly, Town or Lo	cation						1	Od. Insida City Limits
of the Mary or 28s-f sh be notified.	MD N,	'A I	BALTIMO		0-1-				0- 04	10-10-	1 Yes 2 □ No
	10e. Street and Number 4420 EVAMAY ROA	AD #1D		10f. Zip		21215			U.S	.A.	
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1 21215-0 ad within 72 ho ygenre, wer than 'natur it, the Medical.	15. Decedent's Edi (Specify only highast grad	icetion (a complated)	16a. Dece	dant's Usua kind of wor	I Occup	eatlon during most d)	of worki	ng	16b. Kind of B	usinass/Ind	dustry
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ary show man	19a. Informant's Name/Ralationship (T	ype, Print)	19b. Maill	ng Addrass	(Street	and Numbe	r or Rura	l Route Numbe	r, City or Town,	Stata, Zip	Code)
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x 68760, serificate be executed sing physician and se as the bunal-transit Medical Examiner	Sequentially list conditions, if any, laading to immediate cause. Entar Underlying Cause (Disease or injury that initiated evants resulting in death) Last	Dua to (or as a consecutive as	J'AL							
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requir been s should								24a. Was perfor	an autopsy med?	av	era autopsy findings ailable prior to impletion of ceusa daath?
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To the within 2 To the comple	29b. Signeture end title of certifier	and mannar stated. 29c. Licansa number 270339						29d. Data signe			
(18)	30. Name and addrass of person who o	omplated ceusa of daath (Ite	m 23a) (Type,	Print)	ed	Cours	+ n	d: Ba	lhimor	t, 17	DD 2/207
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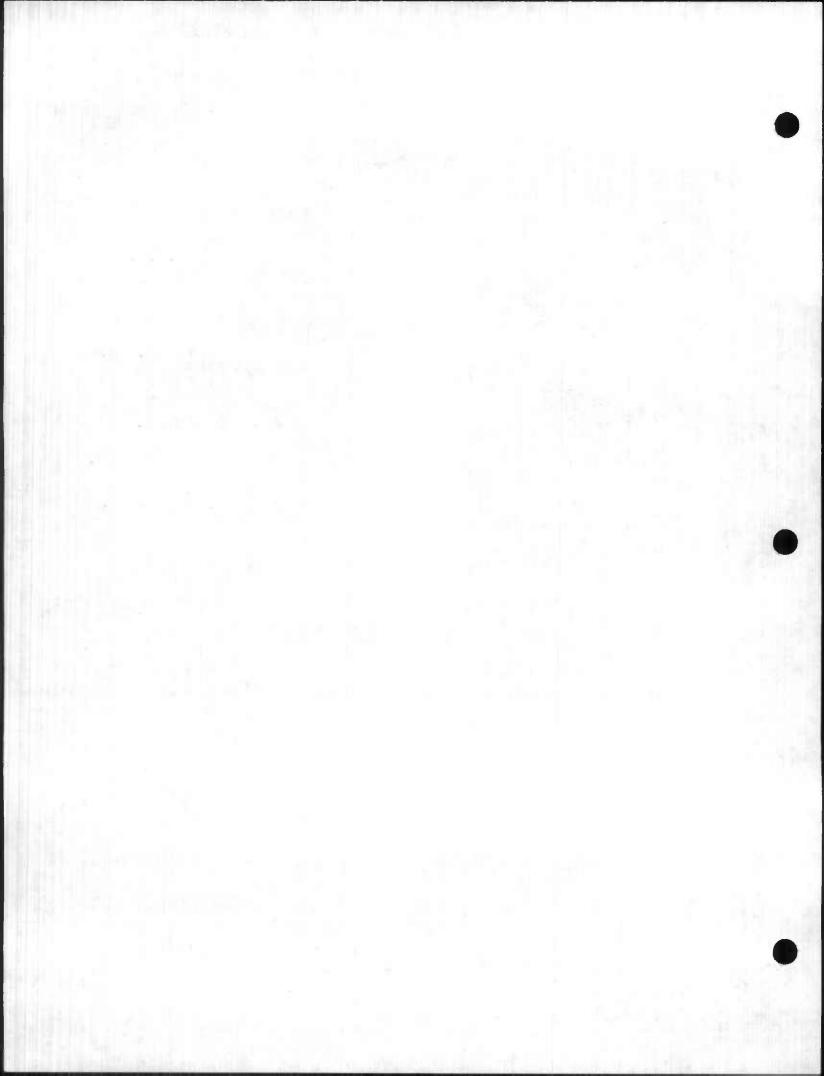
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e-f s	MARYLAND N/A		BALTIM	ORE					XXYes 2 N
or 28e-f s be notified Directo	10e. Street and Number			10f. Zip Code		- 3	10g. Citizen of	What Country	7
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urs after country, or theme 23 Estantions must by Funeral		12. Wes Decedent Ever in Armed Forces? 1 ☐ Yes 2000 No If Yes, Give Yeer or Detes:		Wes Decedent of H II Yes, specify Cube 1 ☐ Yes ※XXNo	ispanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No Ricen, etc.)	Specil	ce - American ack, White, etc.	
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hysician	shock or heart failure. List only	one cause on each line.			1100000			O O	tervel Between nset end Deeth
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APE T	4 ☐ Homicide determined	28e. Plece of Injury - A building, etc. (Sp	At home, term, st ecify)	reet, factory, offica		City or To	wn, Stete)	IDer or nurai n	loute Number,
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· C	30. Negre end address of person who	completed cause of death ((Item 23a) (Type		1 444			- Par Car P	
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DHMH 16 Rev 6/95



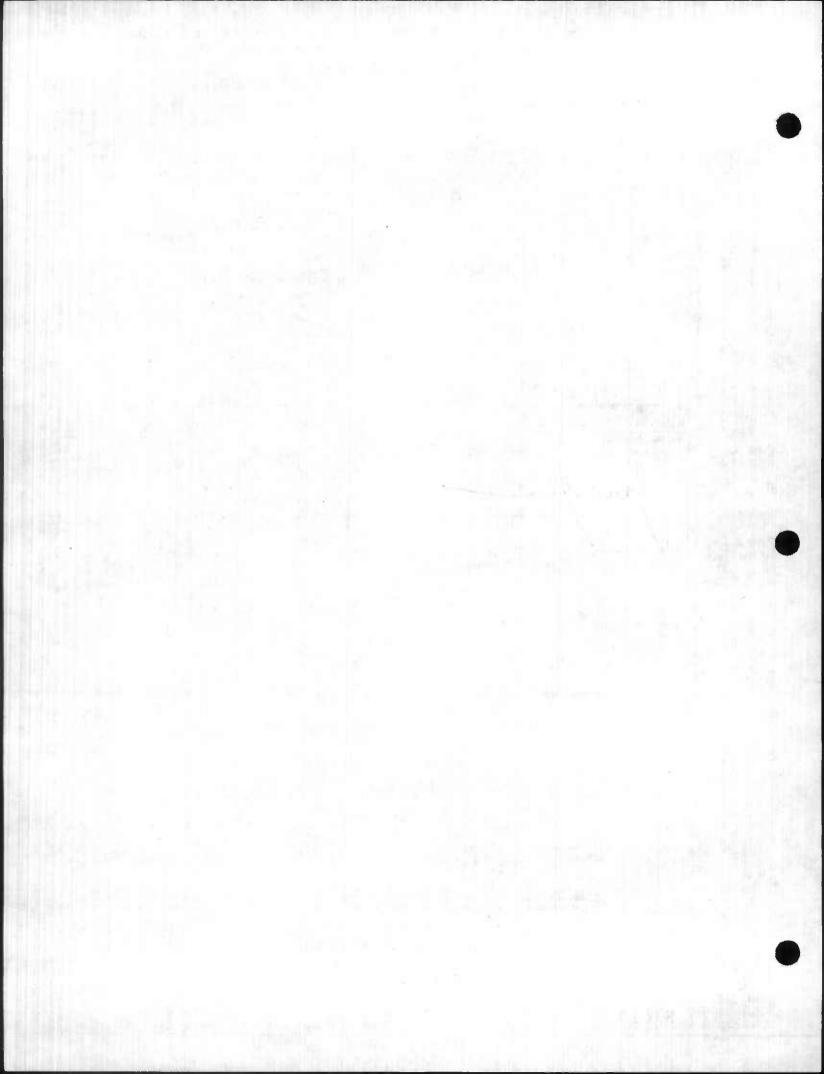
an	1. Decedent's Name (First, Middle,					2. Date of De Month	Reg. No. eath Day	Year	3. Time of Death
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	4a Facility Name (If not institution, Genesis Eld 5. Social Security Number 219-40-3054	ercare Her	(In yrs. last birt	Center thday) If Under 1 Yea Months Days	4b. City, Town, or L Dundalk If Under 24 Hrs. Hours Min.		Balt: 15,191	imore	no (Clata or Enr.
ŀ	Usual Residence of Decedent		40- City Town	and anoting					
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l	3405 North Pe	oint Road		212	22		U.S.A		,,
	11. Marital Status 1 Never Married 2 Marrie 3 7 Widowed 4 Divorced	12. Was Decedent E Armed Forces?		13. Was Decedent of	Hispanic Origin? (S) ban, Mexicen, Puerlo	pecify Yes or No o Rican, etc.)	- 14. Race	- Americe , White, et	ic.
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Registrar



State of Maryland / Department of Health and Mental Hygiene 0 0 36300

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hysician /Medical	Anita Michael	s Earle						Novemb		2000	0300
Examiner	4e Facility Neme (If not institution						4b. City, Town, o	Location of Deat	h 4c. County	of Death	
	Anne Arundel I						Annapoli			Aru	
neral ector	5. Social Security Number 525-58-6349	6. Sex 1 M 2(2)		(In yrs. last bi		Months Day		. (Month, De	rth sy, Year) 17,1932		place (Stete or For ntry) Jersey
	Usual Residence of Decedent			On Chy Ton	Laonti						and traile City I is
fled at	MD Anne	Arundel		10c. City, Tow Annar		lion					1 ☐ Yes %
be notified	10e. Street and Number					10f. Zip Code	G III E		10g. Citizen of \	What Cou	ntry?
D E	128 E. Bay Vie	ew Drive	2			21	403		USA		
at, or terms 23a or 28a-1 show Examiner must be notified at by Funeral Director	11. Marital Stetus 1 Never Merried 2 Mer 3X Widowed 4 Divorce	Arme	Decedent Eved Forces? Yes 2 Noves, Give			s Decedent or es, specify Co	Hispanic Origin? (ban, Mexican, Pue	Specify Yes or Norto Rican, etc.)	0- 14. Rad Blad Specify	ck, White,	can indian, etc. lite
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at to	Clotholitary/Secondary (5 12)	Oolid	5+		achei	r			Educa	tion	
9 9	17. Father's Name (First, Middle	e, Last)					18. Mother's N	ame (First, Middle	, Meiden Sumen	ne)	
o ged	Julius Michael	ls					Sarah	Lasky			
-	19a. Informant's Name/Relation	nship (Type, Print	!)	19	b. Malling	Address (Stre	et end Number or i	Rural Route Numb	per, City or Town,	State, Zi	o Coda)
12.0	Michael Earle	(Son)		7	906 I	Bracks	ford Cour	t, Fairf	ax Stat	ions	VA 220
y or othe	20a. Method of Disposition XXBurial 2 Cremation 4 Donation 5 Other (5		from State	20b. Place of cemeta	of Disposition, cramet	ion (Neme of tory or other p		Date 11/10 2000	20c. Location	City or T	own, State
injur	21. Signature of Funeral Service								- 4	IIS,	MD
o had	market	1		_			ress of Facility Ty Funera				
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	23a. Perul. Enter the disease, of shock, or heart failure. Lis	or complications t st only one cause	hat caused the on each line	ne death. Do	not enter t	the mode of d	ying, such es cardi	ac or respiretory a	arrest,		Approximate interval Between
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dical	Immediata Causa (Final disease or condition	. (MIL	NUME	+ 1	12NB	AST				6 yrs
niner	resulting in death)	а	D	ua to (or as a	conseque	nca of):			77 11 (1)		A-1 113
in and dal-transit Examiner											
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been signed by the attending should be detached for use a leted by Physician/M	Parti. Other significant conditi	iona contributing	to death out	not resorting	in the unioe	onlywig Cause	given in restts.		Yes 20 No	3 □ Pro	
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page Co	25. Was case referred to medica	al					26. Placa of D	eath (Check only	one)		
finicate has been si	numerican and	Hospital:	10 inpatient	2 ER/O	utpatient	3 DOA	Other: 4 Nursing	Home 5 ☐ Res	idenca 8 🗆 Ott	nar (Spec	ify)
director, page	axaminar? 1 ☐ Yes 2 ☑ No	28a. f	Date of Injury (Month, Dey	28b.	Time of	28c. in	jury et	28d. Describe	how injury occur	rred	
eral director, page	1 ☐ Yes 2 ☑ No 27. Manner of Death		Monin, Day	rear)	tnjury		Yes 2 No				
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Are Legible.

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mnmr Marvin J. Feli	na	Please Type or Print in Bia	ack indelible ink. Assure A / Department of Health and	
	-	7 per me G789 11/27/00 yf	Certificate of Death	iviorital rij
	1. Decedent's Name	(First, Middle, Last)		2. Dete of Dea

d item	23a, ptII	, 27 per me	G789 11/27	/00 yf	Cer	tificate of	Death		Reg. No.	001	301
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sician ledical	Marvin	J. Felipa	a					Octobe		Year 000	1820 pm
iner	4e Facility Nam	e (If not institution, gi	ve street end num	ber)			4b. City, Town, or	Location of Deeth			
	20 Nor	th Norris	Street				Baltimo	re	N/A		
	5. Social Securit	y Number 6.	Sex 7	. Age (in yrs. i	last birthday)	If Under 1 Yea Months Days			h v Vear)	9. Birthplace (Country)	(State or Foreign
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	Usual Residence			40.00	-						
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Director	10e. Street and	Number				10f. Zip Code			10g. Citizen of V		
į	20 Nort	th Norris				21217			United		
Funeral	11. Marital Statu		12. Was Deced	ces?	S. 13. V	Vas Decedent of Yes, specify Cu	Hispenic Origin? (Steen, Mexican, Pue	Specify Yea or No- rto Rican, etc.)	- 14. Raci Bled	e - American Ind k, White, etc.	dian,
		larried 2 Married	1 Yes 2		1	□ Yes 2 No	Specify:		Specify Bla	<i>'</i> :	
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Be c		J. Black					Novelle			-,	
19a					Nove					State Zin Cod	01
		Neme/Relationship rvin J. Bl		Father			Street,				9/
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		on 5 Other (Special	-	Mo		on Ceme	-	2000	Baltimo	ore, MD	
	21. Signature of	Funeral Service Lica	14	0	2		Williams				MD
_		John of		- mary			st Baltim				
	shock, or l	er the disease, or con heert feilure. List only	one cause on ee	ch line.	n. Do not ente	er the mode of dy	ying, such es cardie	ic or respiratory ar	rrest,	Inter	roximate rval Between et and Death
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Examiner			b	D /						I	
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TYS	Part II. Other alg	gnificant conditions	contributing to des	un out not rest	aning in the ur	idenying cause (given in Par(I.				4 Unknown
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Completed								_		of death	
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edicai	29a Certifier	1 Certifician D	hyelden: To the t	act of mu kee	wledge death	occurred at the	time date and place	laca, and due to the cause(s) and manner as stated.			
	29a. Certifier (Check only one)		miner: On the bas	sis of examinat							
¥	(Check only one)			sis of examinat		estigation, in my		curred et the time,		and due to the	cause(s)
Me	(Check only one) 29b. Signature a	2 Medical Exa	miner: On the bas	sis of examinat		vestigation, In my	y opinion, death occ	curred et the time,	date and placa,	and due to the	Year)

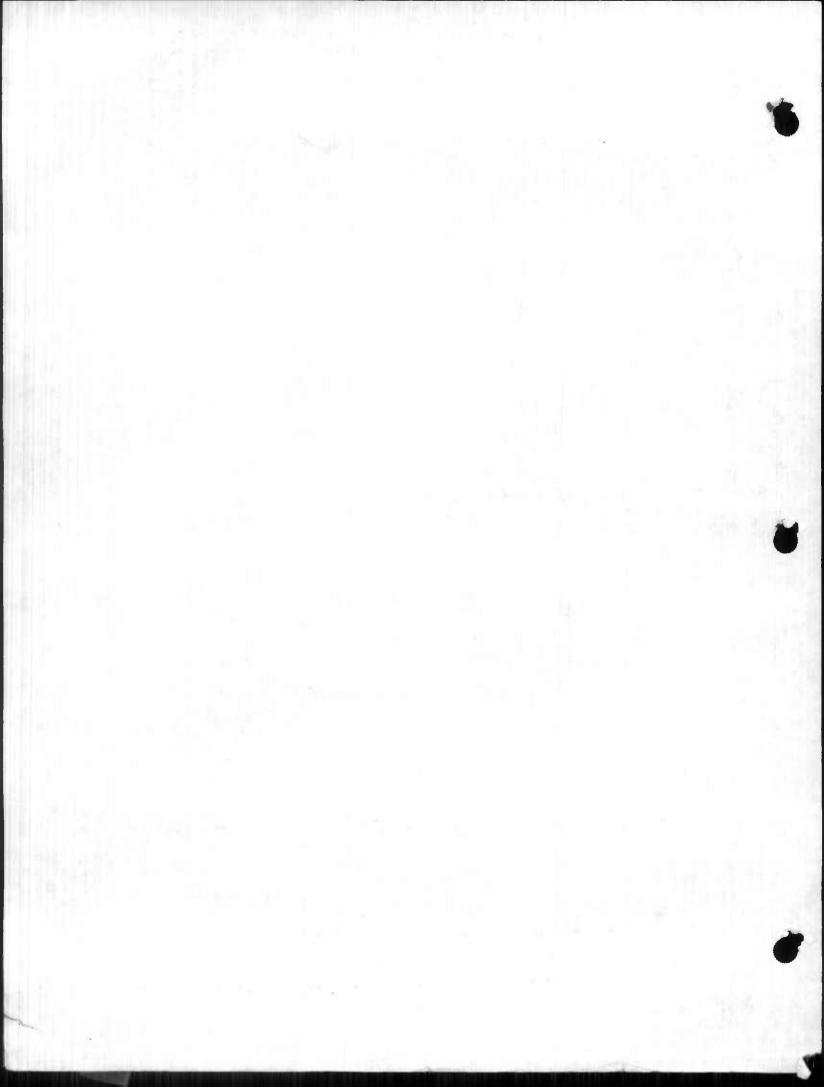
State Registrar

Stephen S. Radentz

Stephen S. Radentz

The Date filed (Month Ray Year)

San Date filed (Month Ray Year) 111 Penn Street, Baltimore, Maryland 21201



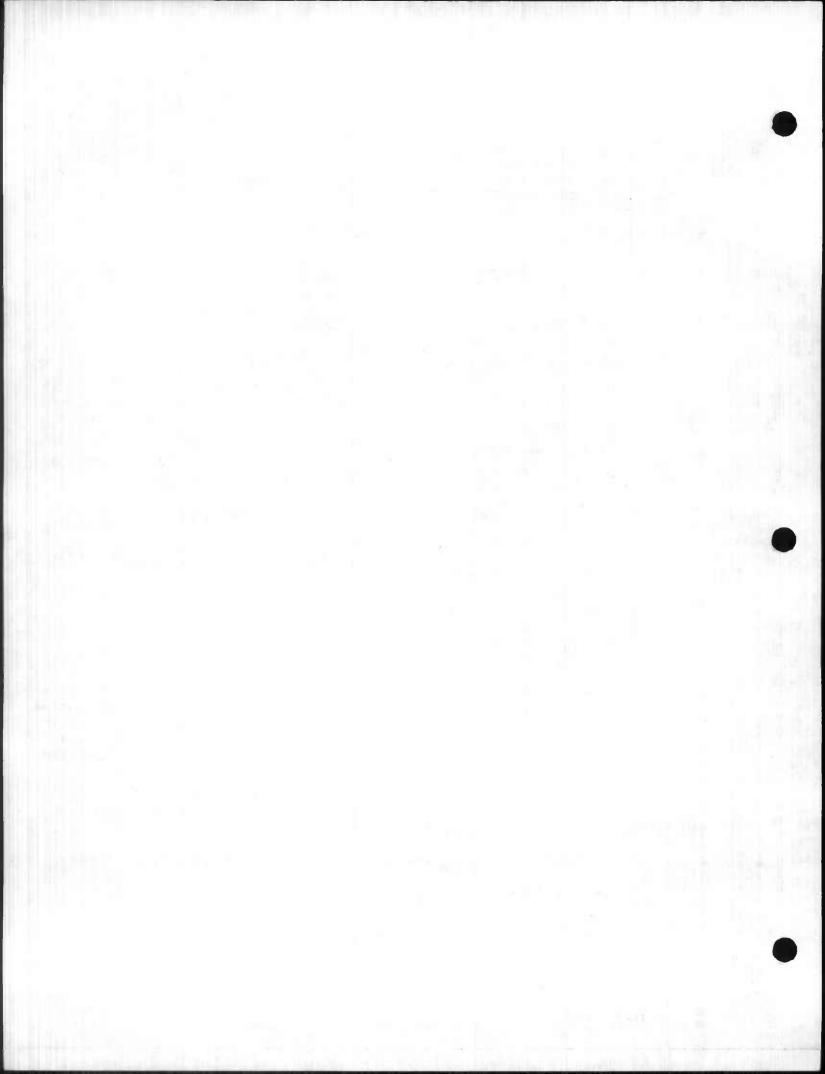
State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month Day Yes **Physician** ANN FARRAR November 12 2000 10:30 am /Medical 4e Facility Neme (II not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOMEWOOD GENESIS-6000 BELLONA AVENUE BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. Months 1□M 2XX Hours 90 **Director** VIRGINIA MAY 10 1910 212-32-9034 Usuel Residence of Decedent 10a. Stete 10d. Inside City Limits 10b. County 10c. City, Town or Location NOXYes 2 No 28a-f Directo MARYLAND BALTIMORE N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ð ä THE 23s Funeral 6000 BELLONA AVENUE 21212 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes ≥ ZX No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 Nevar Married 2 Merried Baltimore, Maryland 21215-0020 8 1 ☐ Yes 2XXNo Specify: Specify: I Hygiena. other than "natural", o ent, the Medical Exan þ 34Widowed 4 □ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) ENVIRONMENTAL SERVICES 12th grade DOMESTIC 17. Father's Nema (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surname) . Pages 1 and 2 should be fit the soft of Health and Mental Hart: If Nem 27 is marked oth illury or other traumatic even Be LONEY TUCKER ERNEST TUCKER 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 5503 Lothian Rd., Baltimore, Maryland 21212 Joyce Credle/Daughter 20b. Plece of Disposition (Neme of cematary, crematory or other place) 20c. Location - City or Town, Stata 20e. Method of Disposition Date 1 ☑Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) KING MEMORIAL PARK 11-17 | BALTIMORE, MARYLAND 22. Name end Address of Fecility
WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 21. Signature of Funeral Service tid Housen 1206 W NORTH AVENUE 23a. Pert Enter ha disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata ervel Bety Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Neumonia 1 week Examiner Dua to (or as a consequence of): Examiner ilcian and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Undarlying Cause (Diseese or Injury that initiated evants resulting in death) Last Due to (or as e consequence of): physician s the burial Box 68760. Physician/Medical Due to (or as a consequence of): 88 for use Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 1 Yas 2 No 1 Yes 2 No certificate Division of Vital or Attending Physician: 25. Was casa referred to medical examiner? 8 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Dey Year) 27. Mannerof Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Atter 5 Panding investigation 1 Metural after death. 1 Yes 2 No 2 Accident 6 Could not be datarmined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, 1erm, street, fectory, office building, etc. (Specify) 2 4 ☐ Homicide filled in 24 hours a Funeral C Hospital 1 Certifying Physician: To the best of my knowledga, deeth occurred et the tima, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or invastigetion, in my opinion, death occurred at the time, data and place, and due to the cause(s) end manner stated. 29a. Certifier Medical completely (Check only within 2 ş 296. Signature and title of certifie 29c. License number 29d. Data signed (Month, Day, Year) 10 217118 13,2000 30 Name end address of person who completed causa of death (Item 23a) (Type, Print) Malrace De 21212 SchWARTZ MA 6 an 115 31. Dete filed (Month, Dey, Year) NOV 15 2000

DHMH 16 Rev 6/95

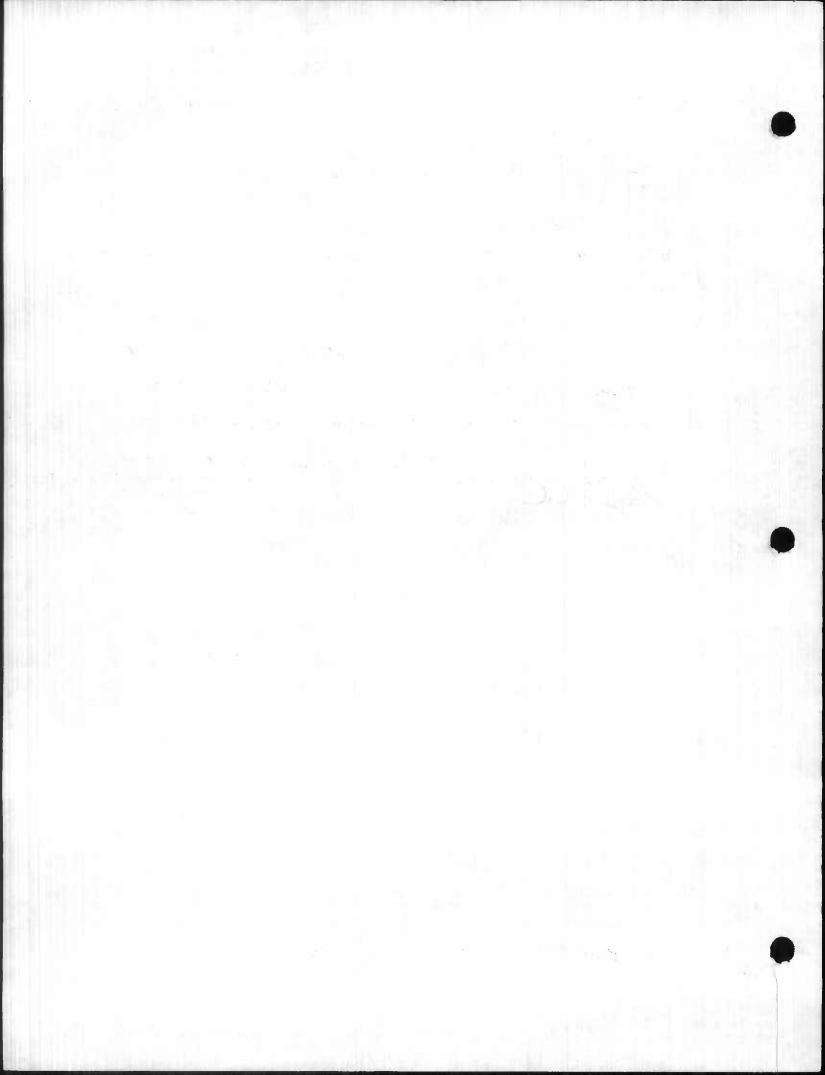
State Registrar 32. Registrar's Signeture



State of Maryland / Department of Health and Mental Hygiene 0 0 36303

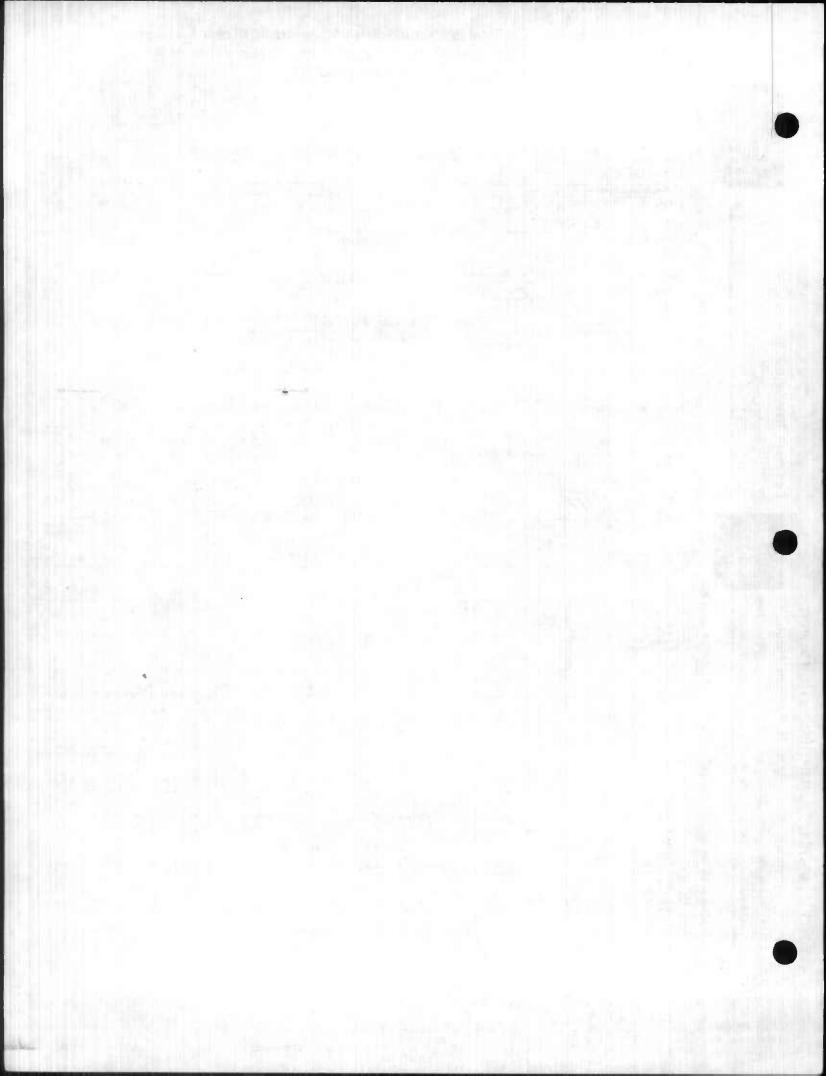
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Dhuaisian	1. Decedent's Name (First, Middle,	Last)					ate of Death	Day	Year 7:2
Physician /Medical	KAITLYN	ELIZABETH		FI	Œ		vem be		
Examiner	4a Facility Name (If not institution,		,		1.0	own, or Location	of Death	4c. County	
	Franklin Squa	re Hospital	cent	er	Kose	odale		Balti	nore
Funeral	5. Social Security Number		yrs. last birtho	dey) If Under		Min. 8. Da	ite of Birth lonth, Dey, 1	(ear)	Birthplace (State or For Country)
Director	214-59-6433	1□M 200F	Yn	s. 1	8		-04-20		Maryland
annexe .	Usual Residence of Decedent								-
ahow dat	10a. State 10b. County	10	c. City, Town o	or Location					10d. Inside City L
28a-f	MD Harfo	rd	Bel Ai	ir					1 □ Yes 2X
or 28a-f a	10e. Street and Number			10f. Zi	ip Code		100	g. Citizen of W	/hat Country?
				2	21014		U	nited S	States
	11. Marital Status	12. Wes Decedent Ever Armed Forces?	in U,S.	13. Was Dece	edent of Hispanic C ecify Cuban, Mexic	origin? (Specify Y	es or No-		- American Indian, k, White, etc.
F 2		d 1 ☐ Yes 2.FyNo					010.)		
D 1		If Yes, Give Year or Dates:		1 🗆 Yes	2 No Specif	γ:		Specify:	white
ygiene. Ner than *natur. It, me Medical Completed	15. Decedent's		16a. De	ecedent's Usu	ual Occupation	at at unding	16	6b. Kind of Bu	siness/Industry
than 'n	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+)	(i	ite. DO NOT	ork done during mo use retired)	ist of working			
on the	0				n/a			n,	/a
T to o	17. Father's Name (First, Middle, Li	ast)	75		18. Mot	her's Name (Firs	, Middle, Ma	aiden Surnem	θ)
Mental mrked control of the several	Richard A	lan Fike			Ka	thleen N	loble	Smith	
Pu	19a. Informant's Name/Reletionshi		19b. N	Aeiling Addres	is (Street and Num	ber or Rural Rou	te Number, (City or Town,	State, Zip Code)
n 27 is ner trau	Mr. Richard Alan	Fike/father	455	5 Rose	Way Bel	Air. Ma	rvlan	d 210	14
IZE	20e. Method of Disposition		Ob. Place of D		me of	Dat			City or Town, State
int: If it	1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe								
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Departm Importa any inju	21. Signature of Funeral Service Si	1 /				Ruck			ral Home, In
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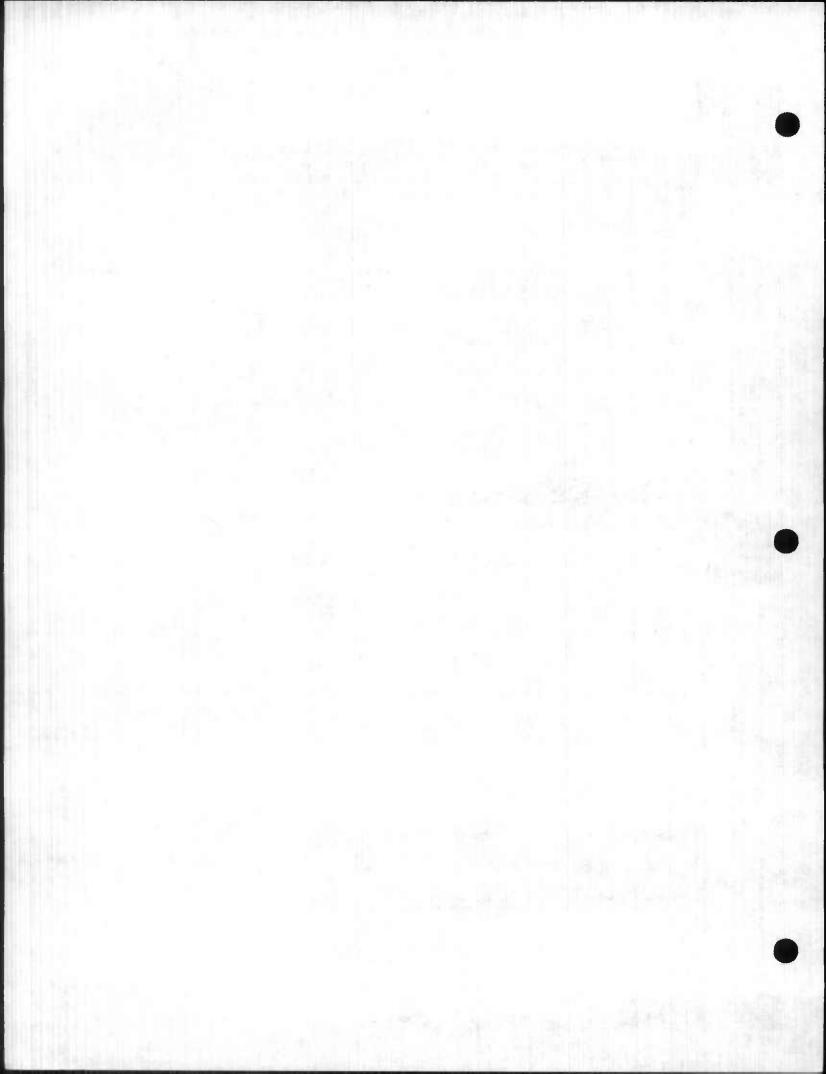


State of Maryland / Department of Health and Mental Hygiene

		AMEND#18 PEF	F.H. G789	11-15-2000	.IAB	Ce	ertifica	te of	Death	F	leg. No.	J	6304
		1. Decedent's Name			OILD			201		2. Date of Dea	th	Year	3. Time of Death
	ysician ledical	MOF	RIS	ISR	AEL		FE	EIN		NOVEMB1	ER 12,	2000	11:45 AM
	aminer	4a Facility Name (II	not Institution, give	street and number,)				4b. City, Town, or L	ocation of Death	4c. Count	y of Death	
1 1 1 1			N HOSPITA				1 1/1/1/1		BETHESDA			GOMER	
Fund Direct		5. Social Security N 125–18–8	860 1	ox 7. Ag	ge (In yrs. 75	last birthda; Yrs.	Months	er 1 Yea s Days		8. Date of Birth (Month, Day DEC.3, 1	924	9. Birthp	olece (State or Foreign htry) NY
9 .		Usual Residence of 10a. State	10b. County		10c. Cit	ty, Town or I	Location					1	Od. Inside City Limits
in the Maryla or 28s-f sho	ctor	MD	MONTGOME	ERY		OTOMA							1 XYes 2 □ No
73 with 19	ust be notified rail Director	10e. Street and Nun 11814 R	OSALINDA	DRIVE			10f. Z	ip Code	20854		U.S.		ntry?
1020 ours after dea	Exeminer must	11. Marital Status 1 Never Marri 3 Widowed	ed 2 Married 4 Divorced	12. Was Decedent Armed Forces' 1 X Yes 2 I If Yes, Give Year or Dates:	?	I,S. 13	3. Was Dec If Yes, sp 1 Yes		Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	pecify Yes or No- Pican, etc.)	14. Ra Bla Speci	ick, White,	en Indian, etc.
5-002 72 hours	ated ated	(Spec	15. Decedent's Ed	ucation de com <i>pleted</i>)		16a. Dec	edent's Us	ual Occu	upation e during most of work ed)	king	16b. Kind of E	Business/In	dustry
121	Completed	Elementary/Secon	nden/(0.10)	College (1-4or	5+)		DO NOT		ed)		PHARMA	~v	
d 2 2	Com	17. Father's Name (Limita	INCID	-	18. Mother's Nam	ne (First, Middle,			
d be selected	o Be	ABRAHAN				FEIN			LINDA	FRETDA	BERKRAL	rr	PRESS
Maryland 21215-0020 of 2 should be fised within 72 hours all this mid Mental hygiens.	T	19a. Informant's Na LTNDA F	me/Relationship (7)			19b. Ma			PLAINVIEW,	ral Route Numbe	r, City or Town		
nore, N ges 1 and 1 of Health If Health	or other	20a. Method of Disp	position	Removal from State		Place of Dis	position (N	ame of	aca)	Date	20c. Location		
Baltimore,	y Injury	4 Donetion 21. Signature of Fu	5 ☐ Other (Specif)		1 BET	TH MOS			and of English	1/14/00 L LEVINS		ROS.,	
00 235	5 8	All	MYM.	with	n				TERSTOWN I	ROAD - P	IKESVI		MD 21208
Physic	ian	23a. Part1. Enter the shock, or heel	ne disease, or comp rt feilure. List only						ving, such as cardiac		rest,		Approximate Interval Between Onset and Death
/Medi Exami		fmmediate Cause (disease or condition resulting in death)		a. Acu		My Cor as a cons			Infarc	tion			10 minutes
70 :	ner ner			Con		y Av		Dife	ase			:	12 years
Security and in and	the burial-transit	Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease or	nditions, imediate			or as a cons	7	f):		100			
68760, fillipse be executed g physician and	edical	Cause (Disease or that initiated events resulting in death) I		С	Due to (c	or as a cons	equenca of	1):					
	(C)			d								1	TO A 1
BOX Beath cert	Cian	Part II Other stanii	loant canditions or	ontributing to death l	but not rec	ulting in the	undadulac	001100	niven in Part Fi	23b Dtd t	obacco usa c	ontribute t	o the cause of death?
	be detached for use by Physician/N	Partin, Other signif		on Pueul			undenying	Cause	JVOIT III F AJC F.		res 2 KNo		bebly 4 Unknown
Cord	should leted									24a. Wes perfo	en autopsy med?	CC	ere autopsy tindings vallable prior to ompletion of cause death?
Vital Red	omp									101	es 2 No		☐ Yes 2MNo
ita In:	Be C	25. Was case reference examiner?	+							ith (Check only o	ne)		
Of V Physici this ce	To E	1 □ Yes 205	NO	Hospitei: 1 inpat		ER/Outpat	ient 3 1	DUA		ome 5 Resid			(hy)
VISION O Attending Ph	funera fon:	27. Manner of Death 1 Anatural 2 Accident	5 Pending investigation	28a. Dete of fnj (Month, Di	ury ay Year)	28b. Time Injun		28c. Inj W	ury at ork? □ Yes 2 □ No	28d. Describe t	low Injury occi	urred	
Division or Attending s effer deeth.	d in by th	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Pieca of Inbuilding, e	njury - At h	ome, farm,	street, facto	ory, offic	0	28f. Location (S City or Tox		ber or Rur	al Route Number,
dospit 4 hours	completely filled in by the funera Medical Certification:	29a. Certifier (Check only one)			of examina				time, date and plece opinion, death occu				
To the vithin 2 To the	Me M	29b. Signeture and	fitle of certifier	4			2		nse number		29d. Dete sign	ed (Month	Dey, Year)
3 - 3 - 3 - 3	, (•	SperalB					-	16052		11/11	2/00	
OBS	.[]	30. Name and address Sjoerol Be	ess of person who	8600 Dld	death (Iter	m 23e) (Typ	Risaul	, Be	ethisda,	MD 20	814		
	State	31. Date filed (Mont	2000 Vear)	San 32 Pagisi	rar's Son	ature A	rocks						



	fle, Last)				2. Date of Dec		3. Time of D	eeth
JOHANNA EL	IZABETH	GISRIEL			Novembe			AM
ner 4e Facility Neme (If not institution	on, give street and number)			4b. City, Town, or Lo	ocation of Death	4c. County of	f Death	
Hospice of Bal				Baltimo			imore	
5. Social Security Number 218-03-1315 Usual Residence of Decedent	6. Sex 1 ☐ M 2 ☑ F	e (In yrs. last birthda 92 Yrs	Months Days	If Under 24 Hrs. Hours Min.	8. Dete of Birt (Month, De Sep. 29	y, Year) 9, 1908	9. Birthplece (State or Country) Md .	Foreign
10a. Stete 10b. County		10c. City, Town or		HE TO LET			10d. Inside City	
X	ltimore	Tows				40-00		
			10f. Zip Code			10g. Citizen of Wh	net Country?	
7925 York Rd. 11. Meritel Stetus 1 Never Merried 2 Mer	12, Wes Decedent	Ever In U.S. 1	21204	lispanic Origin? (Sp	ecity Yes or No-	US 14. Reca	A American Indien,	
1 Never Merried 2 Mer	Armed Forces?	No	3. Wes Decedent of In If Yes, specify Cub 1 ☐ Yes 2 ☑ No		Rican, etc.)	Specify:	, White, etc. White	
0	nt's Education	16a. De	cedent's Usuel Occup	petion		16b. Kind of Bus		
(Specify only highe	(Specify only highest grade completed)		(Give kind of work done during most of working life. DO NOT use retired)					
Elementery/Secondery (0-12)	College (1-4or 5	Acc	ountant			State of	Maryland	
17. Father's Neme (First, Middle,	, Last)			18. Mother's Nem	e (First, Middle,	Meiden Sumame)	
Isadore	Whitest	one		Carrie	Rebe	ecca	Legg	
19e. Informent's Neme/Reletion:		19b. M	eiling Address (Street	end Number or Rur	el Route Numbe	er, City or Town, S	State, Zip Code)	
Mrs. JoAnn Ser	gi/daughter		Ellendale	Dr. Tow		. 21286		
20a. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion	3 Removal from State	20b. Pleca of Discemetery, of	sposition (Neme of cremetory or other ple	ca)	Dete	20c. Location - C	City or Town, Stete	
4 Donetion 5 Other (S		New Cat	hedral Cem	etery 1	1/15/00	Baltim	ore, Md.	
21. Signature of Foreign Service	Lipeosee C		22. Name and Addre	ss of Facility		9.54		
Bout	279/2		1050 York	Rd. Towso	n. Md.	21204		
23a. Pert1. Enter the diseese, o shock, or heert feilure. Lis	r complications that caused t only one cause on each lin	the deeth. Do not ne.	enter the mode of dyi	ng, such es cardiac	or respiretory er	rrest,	Approximete Intervel Between Onset and De	een
Immediate Course (Final			2 1.	0 11				/
Immediete Ceuse (Finel diseese or condition resulting in death)	a (S	ervicat	My	lysthe	7		6 wee	ks
		Due to (or es e con	sequenca ot):	DE IN				
Sequentially list conditions, if any, leeding to immediate	b	Due to free					1	
Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or as a con	sequenca ot):					
Cause (Diseese or injury that initieted events	С	Due to (or es a cons	sequence of):					
	50.17 63	Due to (or es a cons	ocquerioa orj.					
	d			Y I			1	
Pert II. Other eignificant conditi	ons contributing to death b	ut not resulting in the	e underlying cause di	ven in Pert I.	23b. Dld	tobacco use cont	gibute to the cause of	death?
A C	,		3				3 Probably 4 □ U	
Grebrovitse	lar disea	1-9				CEET		
						en autopsy med?	24b. Were autopsy fir available prior to completion of ca of death?	
					репо			-
ompieted to						Yes 2000	_	10
25. Wes case referred to medica	al			26 Place of Deel	101		1 Yes 2 1	16
25. Wes case referred to medical exeminer?	Hospital:	nt 2 FR/Outre	tient 3 DOA Otl	26. Plece of Deel	1 🗆 '	one)	1 Yes 2	ce
25. Wes case referred to medical exeminer? 1 Yes 2 No	Hospitel: 1 Inpatie	ry 28b. Time	e of 28c. Inju	her: 4 Nursing Hory et	1 🗆 Y	one)	1□Yes 2□	ce
25. Wes case referred to medical exeminer? 1 Yes 2 No	Hospitel: 1 Inpatie	ry Year) 28b. Tim- Injur	e of 28c. Inju	her: 4 Nursing Ho	1 (Check only of ome 5 (Check only of ome 28d. Describe)	one) dence 6 🗖 Other how injury occurre	1 □ Yes 2 ℚ (Specify) Hospic	
25. Wes case referred to medical exeminer? 1 Yes 2 No	Hospitel: 1 Inpatie	28b. Time (njur	e of 28c. Inju	her: 4 Nursing Hory et	1 (Check only of ome 5 (Check only of ome 28d. Describe)	one) dense 6 🕱 Other how injury occurre	1□Yes 2□	
25. Wes case referred to redical exeminer? 1 Yes 2 No 27. Menner of Death 1 Neture	Hospitel: 1 Inpatie 28a. Dete of Inju (Month, De) igetion inot be anned 28e. Pleca of Inju building, etc.	y Year) 28b. Time Injury - At home, ferm, c. (Specify)	e of y M 28c. Inju Wo M 1 C	ner: 4□ Nursing Ho ry et rk? I Yes 2□ No	1 Check only of the Check only of the Service 128d. Describe 128f. Location (City or Tou	one) dence 6 XOther how injury occurre Street and Number wn, State)	1 □ Yes 2 □ or (Specify) HOSp1 od	
25. Wes case referred to redical exeminer? 1	Hospitel: 1 Inpatie 28a. Dete of Inju (Month, Deligetion Inot be right) 28e. Pleca of Inju 28e. Pleca of I	ry Year) 28b. Tim- Injury - At home, ferm, c. (Specify) 28b. Tim- tor form, 28b. Tim- Injury - At home, ferm, c. (Specify) 28b. Tim- lor form, 28b. Tim- Injury - At home, ferm, c. (Specify) 28b. Tim- Injury - At home, ferm,	e of y M 28c. Inju Wo 1 C Street, fectory, offica	her: 4 Nursing Hory et rk? I Yes 2 No	1 1 1 2 2 2 3 2 3 2 3 2 3 2 3 2 3 2 3 2	one) dence 6 🖫 Other how injury occurre Street and Number vn, State) ceuse(s) end men	1 ☐ Yes 2 ☐ Or (Specify) Hospic od	
25. Wes case referred to predice exeminer? 1 Yes 2 No 27. Menner of Death 1 Neture 5 Pendi invest 3 Suicide 6 Could deterr 29a. Certifier 1 Certifylic (Check only one)	Hospitel: 1 Inpatie 28a. Dete of Inju (Month, De igetion Inot be nined 28e. Pleca of Inju building, etc ang Physician: To the best of end menner ste	ry Year) 28b. Tim- Injury - At home, ferm, c. (Specify) 28b. Tim- tor form, 28b. Tim- Injury - At home, ferm, c. (Specify) 28b. Tim- lor form, 28b. Tim- Injury - At home, ferm, c. (Specify) 28b. Tim- Injury - At home, ferm,	e of y M 28c. Inju Wo 1 C Street, fectory, offica	ner: 4 Nursing Hory et rk? I Yes 2 No	th (Check only of the company of the	Street and Number wn, Stete) ceuse(s) end mendete end place, et	1 ☐ Yes 2 ☐ Or (Specify) Hospic od	
25. Wes case referred to predical exeminer? 1 Yes 2 No 27. Menner of Death 1 Heturel 5 Pendical invest 3 Suicide 6 Could detern 29a. Certifier (Check only one) 2 Medical	Hospitel: 1	ry Year) 28b. Tim Injur ury - At home, ferm, . (Specify) of my knowledge, de exemination and/or	e of y 28c. Inju Wo 1 Control of the tit investigation, in my 6 29c. Licen:	ner: 4 Nursing Hory et rk? I Yes 2 No me, dete and plece, opinion, death occurse number	th (Check only of the come service) 28d. Describe 1 28f. Location (: City or Touther of the time,	Street and Number wm, State) ceuse(s) end mendete end place, et	T (Specify) Hospic of or Rurel Route Numb oner as stated. Indicate the ceuse(s) (Month, Dey, Year)	
25. Wes case referred to predict exeminer? 1 Yes 2 No 27. Menner of Death 1 Neturel 5 Pendiciple 1 Nest 2 Accident 3 Suicide 4 Homicide 1 Certifyle 29a. Certifier 2 Medical Medical 1 Certifyle 29b. Signeture end title of cartifications	Hospitel: 1 Inpatie 28a. Dete of Inju (Month, De) igetion Inot be nined 28e. Pleca of Inju building, etc ang Physician: To the best of end menner ste Physician: To the basis of end menner ste Market Physician: To the basis of end menner ste Amagenta Physician Stephaner	ry Year) 28b. Tim Injur uny - At home, ferm, c. (Specify) of my knowledge, de exemination and/or	e of y 28c. Inju Wo M 1	me, dete and plece, opinion, death occur se number	th (Check only of the come service) 28d. Describe 1 28f. Location (City or Total only of the time, 1)	Street and Number who, State) ceuse(s) end mendete end place, el 29d. Dete signed	r (Specify) Hospic of or Rurel Route Numb oner as stated and due to the ceuse(s) (Month, Day, Year)	ver,
exeminer? 1 Yes 2 No 27. Menner of Death 1 Prefeturel 5 Pendii 2 Accident 3 Suicide 6 Could 4 Homloide 29a. Certifier (Check only one) 2 Medical	Hospitel: 1 Inpatie 28a. Dete of Inju (Month, De) igetion Inot be nined 28e. Pleca of Inju building, etc ang Physician: To the best of end menner ste Physician: To the basis of end menner ste Market Physician: To the basis of end menner ste Amagenta Physician Stephaner	ry Year) 28b. Tim Injur uny - At home, ferm, c. (Specify) of my knowledge, de exemination and/or	e of y 28c. Inju Wo M 1	me, dete and plece, opinion, death occur se number	th (Check only of the come service) 28d. Describe 1 28f. Location (City or Total only of the time, 1)	Street and Number wm, State) ceuse(s) end mendete end place, et	T (Specify) Hospic of or Rurel Route Numb oner as stated. Indicate the ceuse(s) (Month, Dey, Year)	ver,



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2 Date of Death 3. Time of Death Month 2000 Α. NOV. 11 8:15PM 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death KESWICK MULTI CARE BALTIMORE N/A | H Under 1 Year | If Under 24 Hrs. | 8. Deta of Birth (Months Days Hours Min. | 04/19/1906 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days

1 Yas 2 No

Approximata Interval Batween Onset and Death

months

LYLLYS

1 □ Yas 2 □ No

1 Yes

28d. Dascribe how injury occurred

Other: 4 Nursing Homa 5 Residence 6 Other (Specify)

26. Placa of Death (Check only one)

28c. tnjury at Work?

10 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or invastigetion, in my opinion, daeth occurred at the time, dete and place, and due to the cause(s) and manner stated.

29c. Licensa number

D31025

1 ☐ Yes 2 ☐ No

2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Data signed (Month, Day, Year)

November 14,2000

Funeral Director

Physician

/Medical

Examiner

MARCELLA

1 M 2 F

Directo Funeral p

5. Social Security Number r than "natural", or flams 23e or the Medical Examiner must be Completed

2 should be filed within 7, and Mental Hygiene. Is merked other than "ny h and Mental I permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is m

Physician /Medical **Examiner**

The lew requires that the death certificate be assecuted attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760, signed by the a should l s certificate has b director, deeth. Director: /

Examin Physician/Medical by Completed Be 2 Certification:

Hospital or Attending Physician: To the Hospital within 24 hours a To the Funeral Completely filled edical

217-07-4243 94 \$WITZERLAND Usual Rasidence of Decedent 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 700 WEST 40TH STREET 21211 USA 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Rece - Amarican Indian, Black, Whita, atc. 1 ☐ Yes 2 No If Yas, Giva Yeer or Detas: 1 Never Merried 2 Merried 1 Yas 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) 12YRS TEACHER EDUCATION 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Surname) UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 1 2 0 2 . 111 S. CALVERT ST. SUITE 1400 BALTO., MD. CARLISLE BARTON JR. (ATTY) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Mathod of Disposition Deta 20c. Location - City or Town, Stata 1 ☐ Burial 2 Cremetion 3 ☐ Ramoval from Stata GREEN MOUNT CREMATORY11/14/2000 BALTO., MD. 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility
HENRY W. JENKINS & SONS CO.
4905 YORK RD. BALTO., MD. 21 William K. E andi 21212. 23a. Part1. Entar the disease, or complications that caused the deeth. Do not entar the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Immediata Causa (Final disaasa or condition rasulting in death) . Polmonary hypertension multiple polmonary Sequentially list conditions, if any, leading to immadieta cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware eutopsy findings aveileble prior to completion of cause of death? 24a. Wes an autopsy

Yrs.

29b. Signatura and titla of certifier 30. Neme and addrass of person who completed causa of death (Item 23a) (Type, Print)

25. Wes casa rafarred to medical

5 Pending

Calle way

investigation

6 Could not be

axaminar? 1 Yes 2N No

27. Mannar of Death

1 Natural

3 Suicide

29e. Certifier (Check only one)

2 Accident

4 Homicide

Registra

31. Deta filed (Month, Day, Year) NOV 1 5 2000

CARLA ROSENTHAL M.D. 3333 N. CALVERT ST. BALTO., MD. 21218. 32. Registrar's Signatura

Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Tima of

W

28e. Place of Injury - At homa, farm, street, factory, offica building, etc. (Specify)

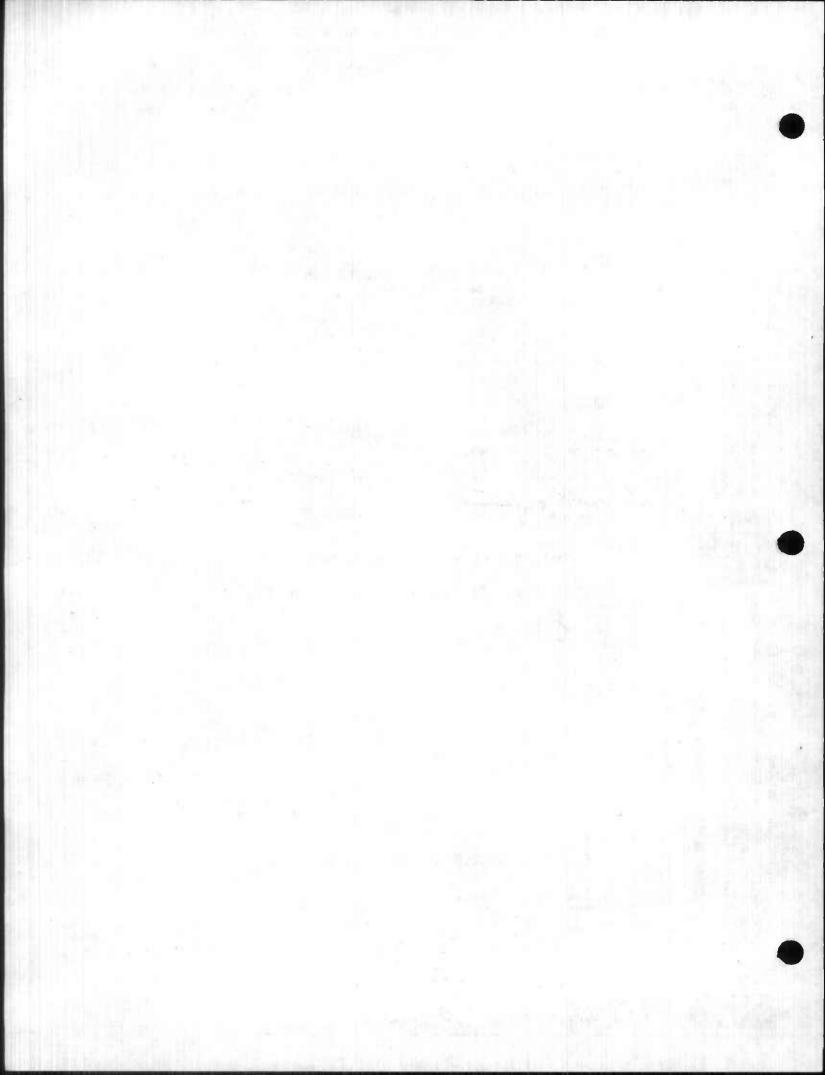
28a. Date of Injury (Month, Day Year)

Rosenthal

oaks

DHMH 16 Rev 6/95

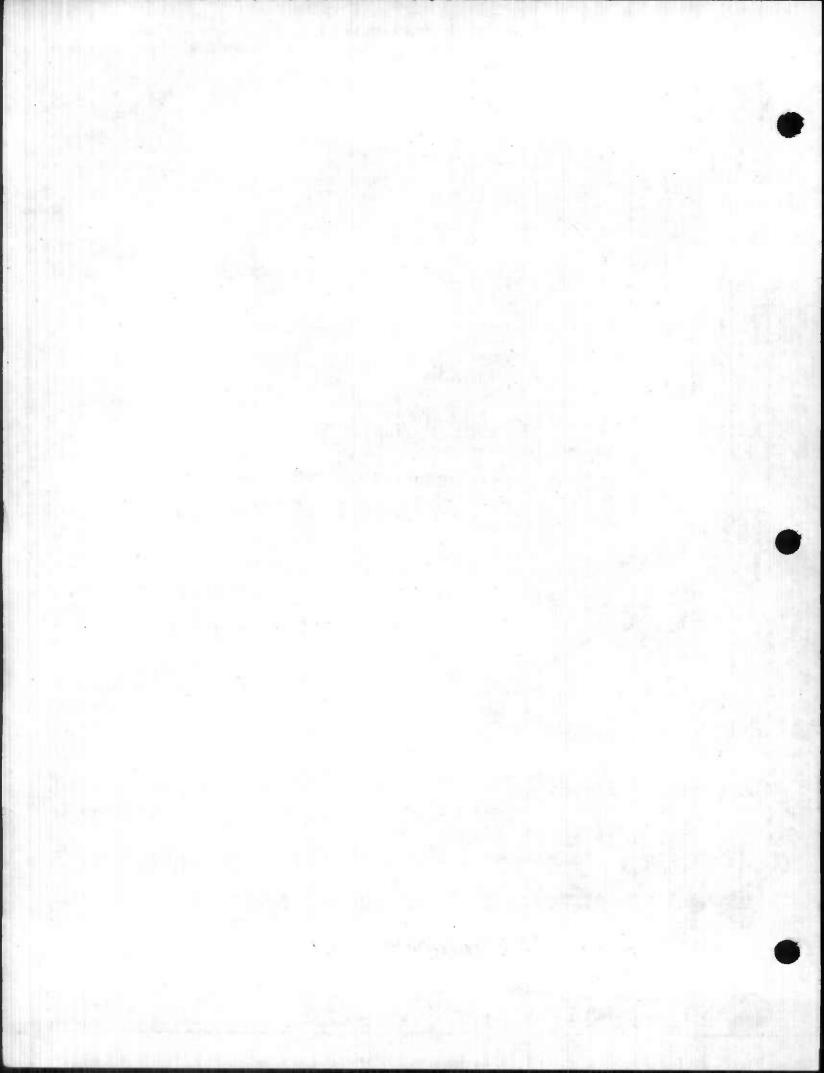
ORIGINAL



Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 36307

			Certificate of Death	Reg. No.
	Physician	1. Decedent's Name (First, Middle, Last)	?	2. Date of Death Month Day Vest 3. Time of Death
	/Medical	SYLVIA ESITHER O	ROSS	November 5 2000 3.16pm
	Examiner	4a Facility Name (If not institution, give street and number	, , , ,	n, or Location of Death 4c. County of Death
		Union MEMORIAL 1		timore n/n
	Funeral		ge (In yrs. last birthday) If Under 1 Year If Under 24 Months Days Hours	Hrs. 8. Date of Birth Min. (Month, Day, Year) 9. Birthplace (State or Foreign Country)
	Director	212-24-8141 10M 218F	73 Yrs. Wall	3-29-1927 md.
2		Usual Residence of Decedent		
- Marie	ahow a	10a. Stata 10b. County	10c. City, Town or Location	10d. fnside City Limits
the Maryland	rotted and rector	Md. N/A	Baltimore	1 ☐Yes 2 ☐ No
with th	or 28	10e. Street and Number Apt. 7	5 10f. Zip Code	10g. Citizen of What Country?
	23a	11 W. 20 10 87.	2/2/8	U.S. A.
death	river mart be notified from Part of the Control of	11. Marital Status 12. Was Decedan Armed Forces	f Evar In U.S. 13. Was Decedent of Hispanic Origin ? If Yes, specify Cuban, Maxican, I	n? (Specify Yes or No- Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc.
effe 6		1 Never Married 2 Married 1 Yes 2 Married 1 Yes, Giva		Constant
5-003	6	3 ₩ Vidowed 4 □ Divorced Year or Dates	TO TOO ELEMANO OPECHY.	specity: Black
5-0 72 h	ygiene. Ner than *naturn it, me treated Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of	16b. Kind of Business/Industry
21 thin	and and	Elamantary/Secondary (0-12) College (1-4or	(Giva kind of work done during most of life. DO NOT use retired)	1/2/11/11/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1
2 \$	Para Co	12th grade n/A	House Keepin	s Noethwest Hosp.
pu #	T S S O	17. Father's Name (First, Middle, Last)	18. Mothairs	Name (First, Middla, Maidan Sumame)
/a	Mente arked To B	LAWRENCE CROSS	ω	lia Montague
Maryland	th and Mer 7 is marke traumatic	19a. Informant's Name/Relationship (Type, Print)	19b. Malling Address (Street and Number	or Rural Route Number, City or Town, State, Zip Code)
N pue		Anthong Streets	3752 Sinclaix	Balto. Md. 21213
5 - E	Heal Item 2 other	20a. Method of Disposition	20b. Place of Disposition (Name of camatary, crematory or other place)	Date 20c. Location - City or Town, State
D Sgg	A # P	1 ■Buriat 2 □ Cremation 3 □ Ramoval from State 4 □ Donation 5 □ Other (Specify)	Voshell Mem.	10/2000 Baltmore Mex
Baltimore	Department o Important: If I any injury or DDCS.	21. Signature of Funaral Service Licenses	22. Nama and Address of Facility	Bets Anenal Home
0 2	Depa Impo any i anca	1 Aug. (1)/1-11	tu	
W		23a Part Foly the disease or complications that cause	of the death. Do not enter the mode of dyling, such as of	1116 01 2000
		23a. Part. Enter the disease, or complications that cause shock or heart failure. List only ona causa on each	lina.	Interval Between Onset and Death
	ysician Medical	Immediate Cause (Final	1 11 :-	2
	aminer	disease or condition resulting in daath)	srhythmia	3 minutes
	- b	1	Due to (of as a consequence of):	
9	nsit min	b. /ts	piration	UNKNOWN
Mecu	ician and burlal-transit	Sequentially list conditions, if any, leading to immediate cause. Enler Undertying Cause (Diseasa or Injury	Due to (or as a consequence of):	3 .
68760		cause. Enter Undarlying Cause (Diseasa or Injury	ic Obstructive Yuln	nonary Disease Unknown
ox 687	physicials the bu	that initiated events rasulting in daath) Last	Due to (or as a consequenca of):	
M 6	M M	d		
Box	d by the attendi etached for us. Physician/			
. 8	the the y	Part ff. Other significant conditions contributing to death	but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death?
P.O.	ed by the attedeteched for			1 Yee 2 No 3 Probably 4 Unknown
8 5	5.8			
Records,	should should			24a. Was an autopsy performed? 24b. Ware autopsy findings availabla prior to completion of cause
D M	has by			of death?
	page Com			1 Yes 2 No 1 Yas 25 No
Vital	certificate rector, pag	25. Was case refarred to medical examinar?	26. Placa o	of Death (Check only ona)
of Vita	this certific al director,	1 Yes 2 No Hospital: 1 Inpar	iant 2 ER/Outpatient 3 DOA Other: 4 Nurs	sing Home 5 Residence 8 Othar (Specify)
- D	2 6 C	27. Manner of Death 28a. Date of In	ury 28b. Tima of 28c. Injury at Work?	28d. Dascribe how Injury occurred
Vision	ath. r: After se funer ation	1 Natural 5 Pending (Month, L 2 Accident investigation	M 1 Yes 2 N	0
Division or Attanding	by th	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of I building.	njury - At homa, farm, street, factory, offica	281. Location (Street and Number or Rural Route Number, City or Town, State)
0 0	is after death. In Director: After the in by the funera Certification:	oblining,	ic. (Specify)	
apple.	within 24 hours sher death. To the Funeral Director: Ah completely filled in by the fur Medical Certification		t of my knowledge, death occurred at the time, data and	
ž ,	he Funeri pletely fill edical	(Check only one) 2 Medical Examiner: On the basis and manner:		occurred at the time, date and place, and due to the cause(s)
To th	To the	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		HOUNG Wille	enigh 000559	77 November 6,2000
		30. Name and address of person who completed cause of	death (Italy 42a) (Time Brint)	
		Robert H. Williams Tu	MD - 201 E Univer	rsity Parkway
	State	31. Date filed (Month, Day, Year) 32. Regis	trar's Signature	
	Registrar	NOV 1 5 2000 \	eperos B Goods	



State of Maryland / Department of Health and Mental Hygiene U

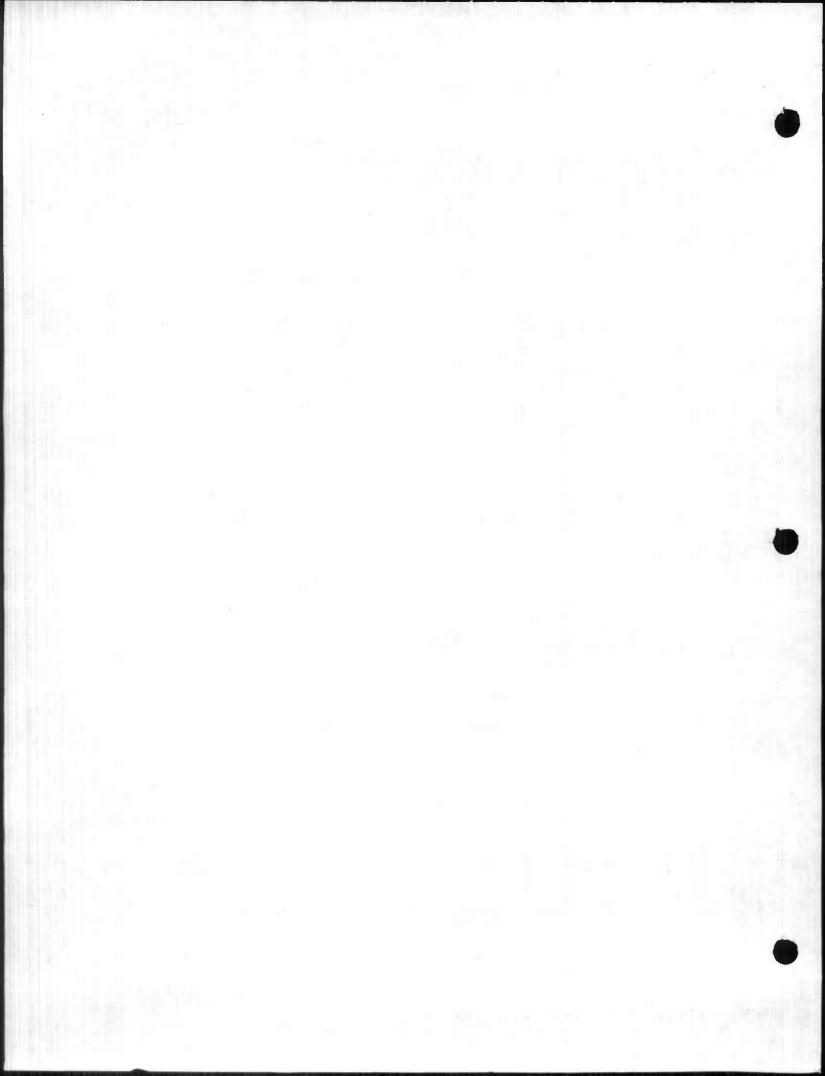
Certificate of Death amend item 23a per md G789 11/15/00 yf 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** IRENE TAWNEY HARBAUGH NOVEMBER 02, 2000 11:47 A.M. /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Name (If not institution, give street end number) Examiner WORCESTER BERLIN NURSING & REHAB CENTER BERLIN If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Yes Apr 29, 1 Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) **Funeral** 1□M 2\ F Months Deys Hours Yrs. 86 Director 214-16-1912 Usuel Residence of Decedent 10b. County 10a. Stete 10c. City, Town or Location 10d. Inside City Limits MD Worcester Berlin 1 ☐ Yes 2X No Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8 than "natural", or items 23a 9715 Healthway Drive 21811 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Meritel Stetus 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried Maryland 21215-0020 1 Yes 2 No Specify: White by 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuef Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 0 sales clerk retail 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fill Department of Health and Merral Hy Important: If them 27 is marked oth Bry Injury or other treumstic even otics. Charles Thomas Tawney Lillian Mancha 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Robert Harbaugh/son 12910 Pine Street Ocean City, MD 21842
Dete 20c. Location - City or Town, State Baltimore, 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 1 Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) 21. Signeture of Funeral Service Licensee Royald S. Wade, 22. Name and Address of Fecility Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Z3a. Pert1 Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or heart feiture. List only one cause on each line. Approximete Interval Between Onset end Death Physician /Medical Immediate Ceuse (Final NEUMONIA ASPIRATION disease or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last ed by the attending physician and detached for use as the burial-trar Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequenca of) Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by 1 Yes 2 No 3 Probably 4 Unknown þ 2 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? should Completed certificate has 1 ☐ Yes 2 No 2 No 1 Yes or Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient To 1 Yes 2 No Other: XXNursing Home 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) this funeral 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred s after death.

I Director: After the in by the funera 27. Menner of Death 28b. Time of Certification: 5 Panding 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral I 29e. Certifler 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and dua to the cause(s) and manner as stated edical 2 Medical Examinar: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and dua to the cause(s) (Check only end menner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of certifie D02026 of death (New 23a) (Type, Print) DR. FEDERICO ARTHES 30. Neme and address of the 246 TEAL CIRCLE, BERLIN, MD. 21811 32. Registrer's Signeture 31. Dete filed (Month, Day, Year) State NOV 1 5 2000 Registra

DHMH 16 Rev 6/95

HARBAUGH, IRENE

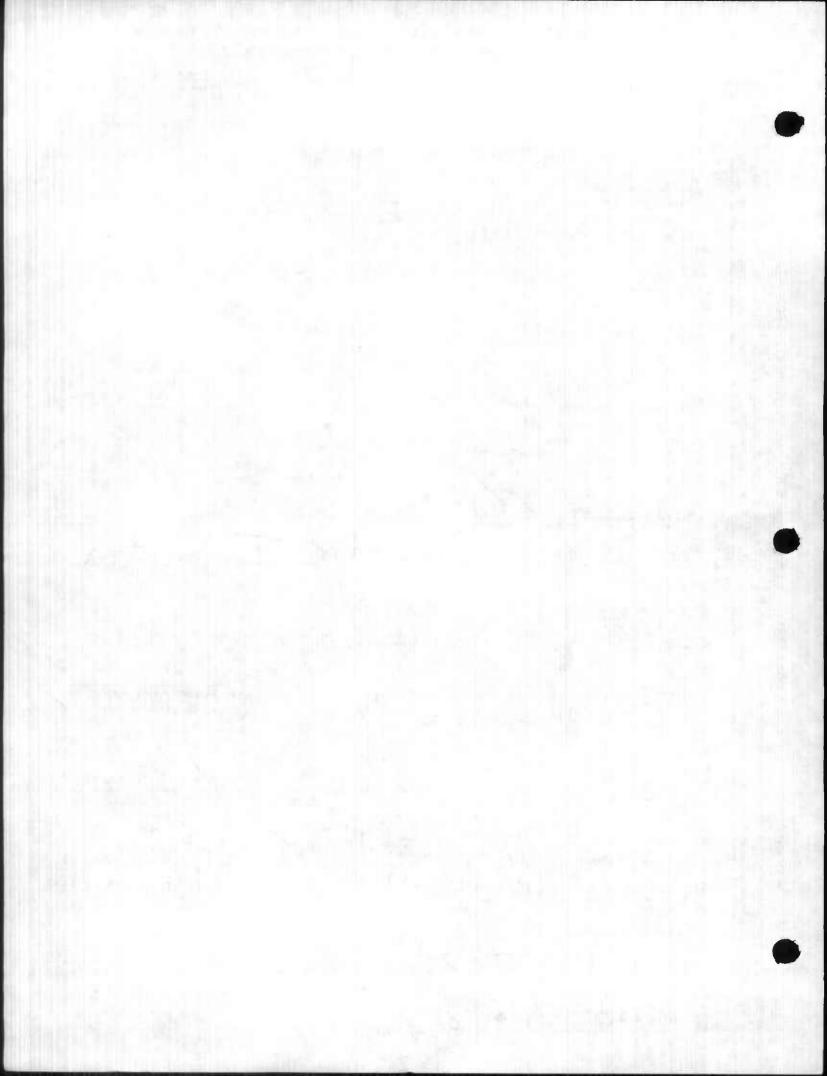


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State of Maryland / Department of Health and Mental Hygiene

James Hi	11					Certi	ificate of	Death			Reg. No	. UL	3	630	9
		1. Decedent's Nama (Fire			***					2. Data of Do	eath Da	ıv	Yaar	3. Time of	Death
	ysician ledical	JAME	S	J	HI	بابا				Novemb			2000	12:50	P.M.
	aminer	4a Facility Name (If not i	nstitution, give str	reet and number)				4b. City, Tov	wn, or Loc	cation of Dea	th 40	. County	of Death		
			West No			206	Millader 1 Van		timo				N/A	- 12	
Fun Dire		5. Social Security Number 142–36–165 Usual Residence of Dece	6 1111	7. Ag	ge (In yrs. last i	Yrs.	If Under 1 Yea Months Day		Min.	8. Date of Bi (Month, D 10-9-	rth ay, Year 194	7	9. Birthple Count N .	ace (State of try).	r Foreign
B 8			County		10c. City, To	own or Loca	ition						10	od. Inside Cit	ty Limits
ith the Maryla or 28a-f shor	Director	MD 10e. Street and Number	1000		BAL	TIMO	RE				100 Ci	itizen of W	That Count	1X Yas	2 No
ath with 23e or	8 0	2214 E. M	ADISON				2120)5				U.S	.A.		
0020 ours after de raf. or item	Examiner must	11. Marital Status 1 Never Married 3 Widowed 4 1	Married	Was Decedent Armed Forces? 12 Yes 2 If Yes, Give Year or Dates:	7		as Decedent of as, specify Cu		in? (Spe , Puerto F	city Yes or N Rican, atc.)	0~	Blac	- America k, Whita, e BLAC	etc.	
Maryland 21215-0020 at 2 should be liked within 72 hours at the and Mental Hygene. This marked other than "natural", or	Completed	15. (Specify on Elementery/Secondary 12	Decedent's Educe by highast grada ((0-12)	tion completed) College (1-4or :	5+)	Sa. Deceder (Give kin life. DO	nt's Usuel Occi nd of work don NOT usa retii RER	upation e during most red)	of workin	09			Siness/Ind		
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	er traum	19e. Informant'a Name/F REBA JACKS		o, Print)	2	2214	E. MA								
Baltimore, semit. Pages 1 a Apartment of Nea mportant: if Nam.	no ou on	20a. Method of Disposition 1 Page 12 Cre 4 Donation 5 December 2	mation 3 Ren	moval from State	ceme	tery, crema	tion (Name of tory or other p		4 4	Date 21-00			City or Tov	wn, State LS MD)
Balti Departm Importa	any inju	21. Signature of Funeral EUGENE		Ed.	1/1/6	22.1	Name and Add	ress of Fecility	EST	EP BF	ROS	FUNI	ERAL	SERV	
		23a. Part1. Enter the dis	ease, or complica	elons that cause	the death. D		the mode of d					RE I		1217 Approximate Intervel Beh	.0
Physic /Med Exami	ner	Immediate Cause (Final disease or condition rasulting in death)	a.	cause on than i	Due to (or as	no	oti	ic	I	n	ox	e cai	tio	Onset and I	Death
pernied	Examiner	Sequentially list condition	ns, b.		Dua to (or as	a conseque	ence of):	2							
9	es the bur	Sequentially list condition if any, leading to immedia ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. d.		Due to (or as	a consequa	ance of):								
BOX death cer	d for	Part II. Other significant	conditions contr	buting to death b	out not resulting	a in the und	lerlying ceuse	given In Part I.		23b. Dlo	tobacc	o use cor	ntribute to	the cause of	of pleath?
P.O.	be detached for use a by Physician/M	Coc	ain	e	Use					10) Yes	2 No	3 Prob	nably 4	Unknown
Cord requir	should									24a. Wa	s an euto	opsy	ava	ere autopsy f allable prior t mpletton of c death?	findings to cause
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of Vita Physician: this certific	Be (25. Was case referred to examiner?	-						of Deeth	(Check only	one)				
of of	To To	1 Yes 2 No 27, Manner of Death	Ho	spitel: 1 Inpatte		Outpatient b. Time of /	311 000			ne 5 Res				Scen	<u>ie</u>
Ming I	tion	1 Natural 5	Pending investigation	(Mgrith, Og	Year)	Injury (juryat /ork? □Yes 2131		1		al & a	1.)0		
Division of Vital Reconstructions of Vital Reconstructions after death. The Law of Process of Proc	led in by the funera Certification:	2 Accident 3 Suicide 8	Could not be determined	250. Flece of Injuriding, of	jury - At home,	0	et, factory, offic			281. Location City or To	(Street a	te)	er or Rura	A Route Num	nber.
DIVI To the Hospital or Att within 24 hours after of To the Funeral Direct	edicai C		Certifying Physic Wedical Examine		of my knowled	ige, deeth o						s) and ma	innar as st		5)
To the	Mec	29b. Signeture and title	certifier	ond monitor St	AAF	\	29c. Lice	nsa number			29d. D	ate signe	d (Month, i	Day, Year)	
Me		30. Name and address of	parson who com	pleted ceuse of	death (Item 23	e) (Type, P		O.C.M.E	ā.		1	Voven	ber 2	2, 200	10
	State	Joseph Pes 31. Date filed (Month, Da NOV 1 5 20	y, Year)	1.D 32. Registr	rar's Signature		Penn St	treet,	Balt	imore,	Mai	rylar	d 213	201	
	gistrar	MONTOS	100 /	ener	19.	Loa	the								
DHMH 16 Re	A PAR														



State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Augustus Francis Hebron 11, 2000 5:40p.m October /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fort Howard VAMHCS Fort Howard Division If Under 1 Year If Under 24 Hrs 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 M 2□ F Days Months 70 214-26-3400 Director Usuat Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If fem 27 is marked other than "natural", or hams 23 or 28a-f show any liqury or other traumatic event, the Medical Exempter must be notified as applied. 10a. Stata 10b. County 10c. City, Town or Location 10d, toside City Limits 1 Yas 2 No Director Baltimore MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 325 A Melvin Avenue 21228 USA Funeral 12. Was Decedant Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 14. Race - Amarican Indian. Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: Never Married 2 Married 1 Yes 2 No Specify: Specify: þ BLACK 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) Comp Elementery/Secondary (0-12) College (1-4or 5+) Glen L. Martin Mechanic's Helper 12th 18. Mother's Name (First, Middle, Maiden Sumama) 17. Father's Name (First, Middle, Last) Frances E. Hebron Minnie Wellings 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 1109 Arunah Ave., Balto, Md 21228 JoAnn Hebron-Bordan 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removal from State Garrison Forest Vet. 10/18 OwingsMills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addrass of Fecility Nutter Funeral Home Inc. 2501 Gwynns Falls Pkwy., Balto., Md 21216 kutter exhirt 23a. Part1. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one couse on each line. Approximate tnterval Between Onsat and Death **Physician** tmmediete Causa (Final disease or condition resulting in death) /Medical 2 months Metastatic Esophageal Cancer Examiner Due to (or es a consequence ot): Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 thet initiated events resulting in death) Last Due to (or as a consequence of): 23b. Dtd tobacco use contribute to the cause of death? Part ft. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. been signed by the should be detached 1 Yaa 2 No 3 Probably 4 € Unknown þ 24b. Were eutopsy tindings available prior to completion of ceuse ot death? Completed 24a. Was an autopsy performed? page 2 s 1 Yes 2 No 1 ☐ Yes 2 No certificate Hospital or Attending Physician: 25. Was cese referred to medical examiner? director, 8 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No 20 After this funeral d 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending Invastigation 1 Natural 1 Yes 2 No To the Hospital or Attendit within 24 hours after death.
To the Funeral Director: A completely filled in by the fu 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 ☐ Could not be 3 Suicida Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical

State Registrar

-0

29b. Signature and title of certifier

9600 North Point RD, Fort Howard, MD 21052 III, MD George E. Wicks 32. Registrar's Signy dure 31. Date filed (Month, Dey, Year) NOV 1 5 2000

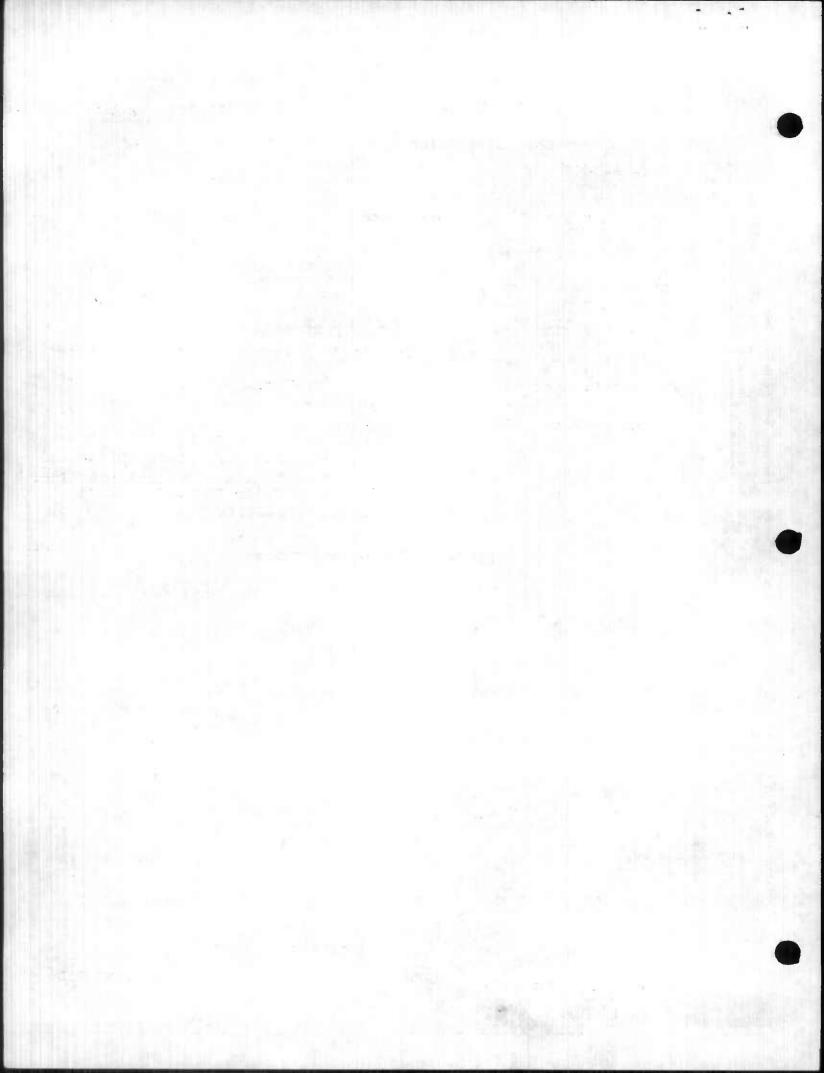
30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

Wills IM MD

29c. License number

D41365

29d. Date signed (Month, Day, Year)

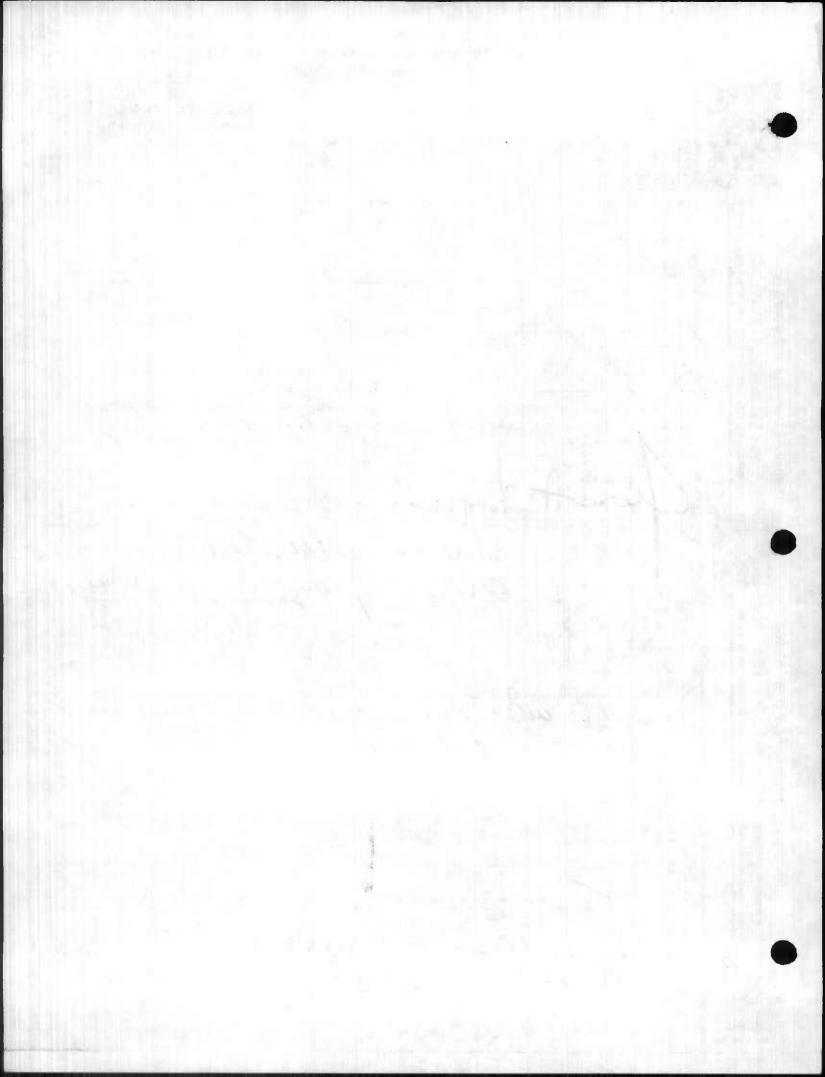


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AMEND FIEM: 17 PER F.H. G789 11-15-00 WK. State of Maryland / Department of Health and Mental Hygiene 0 0 3 6 3 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** NOU 10:2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funera Months Days Hours XXM 2DF 70 Director 215-24-2913 09 04 30 M.D. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10e. State 10b. County 1 Yes 2 □ No Baltimore Directo MD NA 23s or 28s-4 must be notifi-10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21212 1005 Lenton Ave 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 Yes 2 No Specify: 3 XWidowed 4 □ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Butcher Meat Company 12th grade Maryland 17. Father's Neme (First, Middle, Last)
JESSE T. HORION 18. Mother's Neme (First, Middle, Maiden Surname) 1 and 2 should be fill Health and Mental H im 27 is marked oth Ethel L. Henry Kesse T. Horton 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health : 1005 Lenton Ave, Baltimore Md Fenton Horton Sr.-Brother Baltimore, 20e. Method it Disposition
1 ☑ Duri 1 2 ☐ Cremelion 3 ☐ Removel from State
1 ☐ Doction 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 Crestlawn Memorial 11/16/00 Baltimore MD 22. Name and Address of Facility
March F/H West 21 Signature of Funeral Service Ligansee 23a Faril. Enter the disease, or complications that caused in death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line 4300 Wabash Ave, Baltimore Md 21215 Approximete Interval Between Onset and Deeth **Physician** /Medical tmmediale Cause (Final disease or condition resulting in death) sear Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably Wunknown of Vital Records, Be Completed by 24b. Were autopsy findings 24a. Was an autopsy performed? available prior to completion of cause of death? 20 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No at or Attending Physician: T s after death. Il Director: After this certificat ed in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Medical Certification: To 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Division 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) & Wilchwelere are fall nore 2434 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture Registrar NOV

ORIGINAL



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JUNE	Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 3 6 3 1 2
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Examiner			01/00/ 01/07/07/00				ELKTO			COUNT	rν
Funeral Director	5. Social Security I	Number 6. Sa	IX 7./	Aga (In yrs. I	last birthday) Yrs.	If Undar 1 Yas Months Day	ar If Under 24 Hrs	8. Date of Bir	th ey, Year)		ce (Stata or Foreign
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20 n after death t, or items 2: carrière mus	11. Marital Status	ried 2 Married	12. Was Deceder Armed Forca: 1 Yes 25 If Yes, Give Year or Dates	s? No			f Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or No to Rican, etc.)		e - American ck, Whita, ato	0.
o de la		15. Decedent's Edi		s.	16a. Deced	lent's Usual Occ	cupation		16b. Kind of Br		ite
Maryland 21215-0020 d 2 should be filed within 72 hours at the and Mental Highene. T'te merked other than "natural", or traumatic event, the Medical Exam. To Be Completed by I	(Spe Elementery/Sec 12	cify only highest grad	ta completed) College (1-4o	or 5+)	(Giva	kind of work dor DO NOT use ret None	ne during most of wo	orking		None	
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ylan Wents	Michael	A. Hann,	SR		1000		Glady	ys M. Gl	ass		
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Hospital 24 hours Funeral stely filled	29a. Certifier (Check only one)			of examinet			time, date end place y opinion, death occ				
within 2 To the comple		title of certifier	and mainler	aratev.		29c. Lice	anse number		29d. Date aigne	d (Month, De	ey, Year)
	Alt	ysh b	Me	reh	5,1	p 0.	C.M.E.	11/4	NOVEMBE		
- 4	30. Name and add	ress of person who o	ompleted cause of	t death (Item	23a) (Type,	Print)					

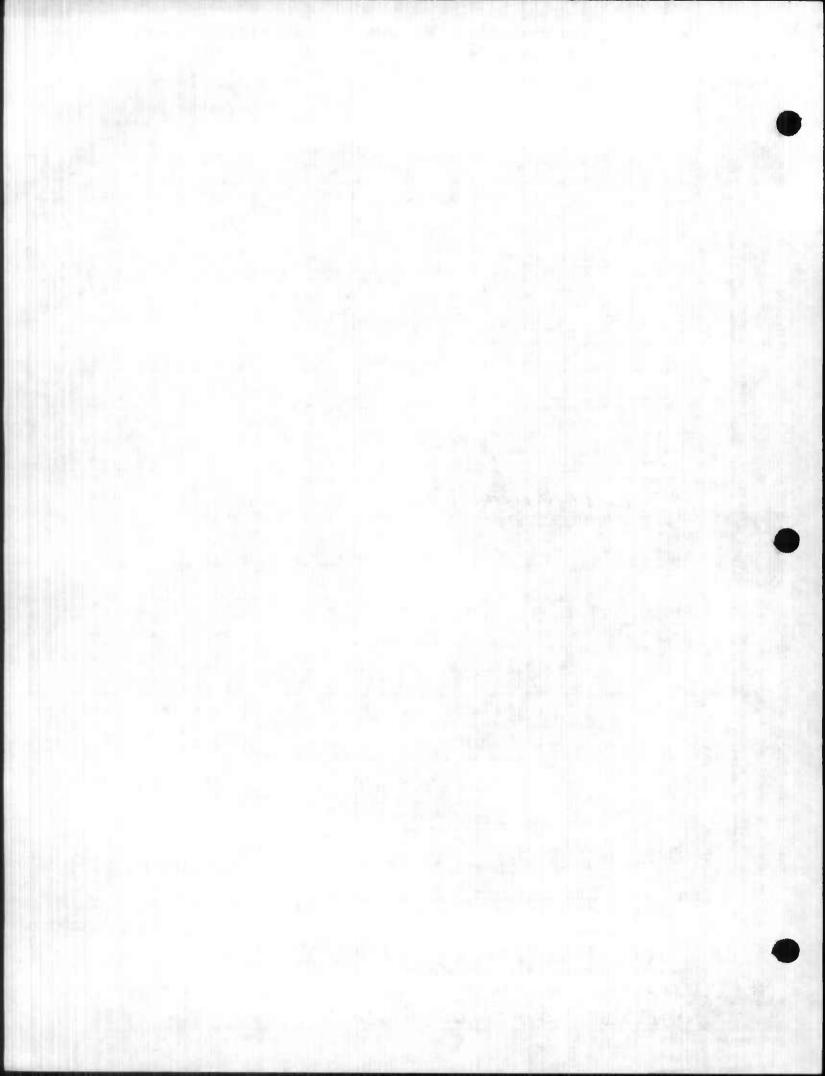
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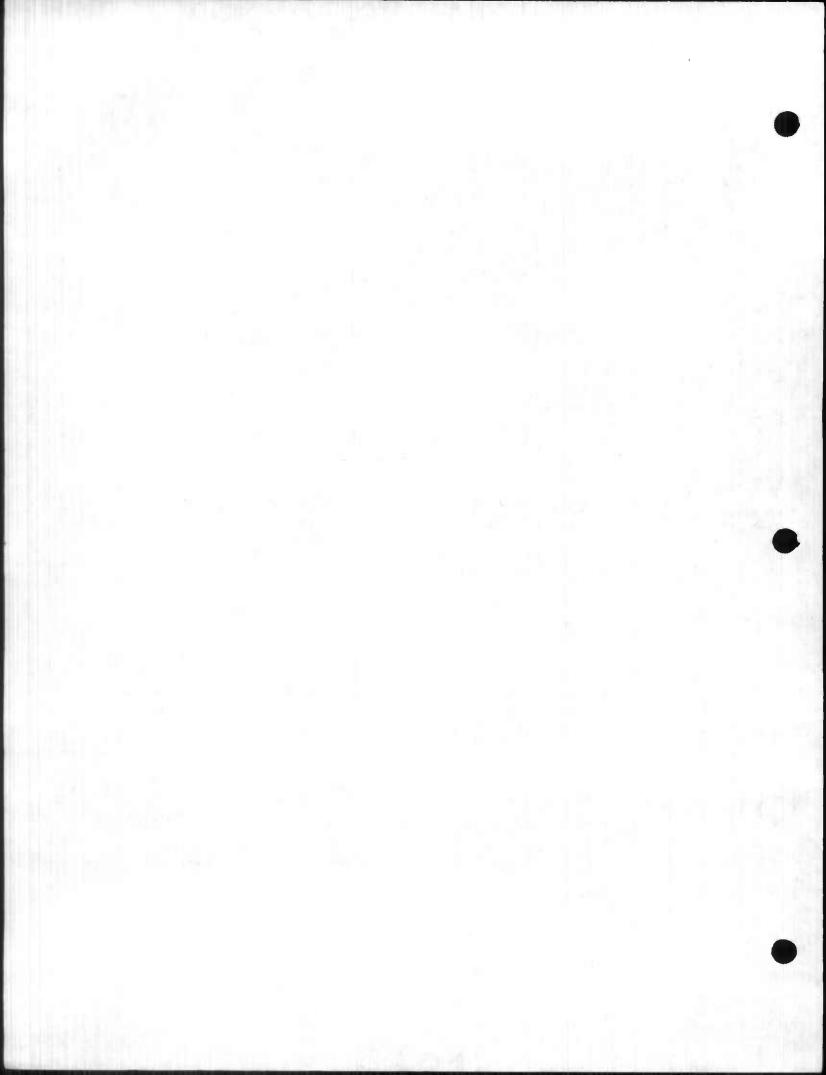
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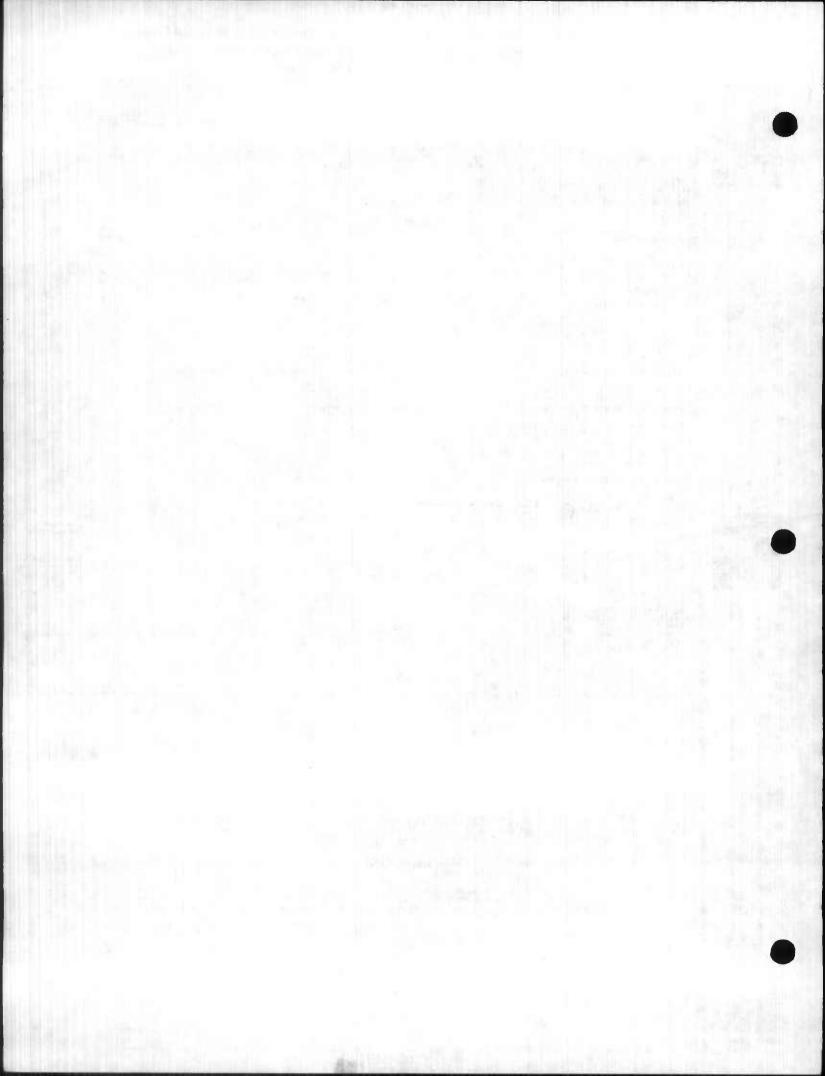
State of Maryland / Department of Health and Mental Hygiene 1 3 6 3 1 3

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	Physician	Zenobia Veronica Jackson 48 Facility Name (If not Institution, give street and number)									Month NOV.	10, 200	Year	11:48 AM
	/Medical Examine	4.0	Facility Name (/	f not institution, gi	ve street and number	r)			- 4	lb. City, Town, or	Location of Deat			11.40 A
	LAdititic		2001	MCCULLOH	STREET					BALTIM	ORE	Balti	more	City
	Funeral Director		Social Security N		Sex 7. /	Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs Hours Min.	(Month, De		9. Birthpi Coun	lace (State or Foreign try) ryland
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anda	ahow a	. 1	a. State	10b. County	an City	10c. Cr	ty, Town or Loca						- "	0d. Inside City Limits 1 Yes 2 No
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	hysician													Onset and Death
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ecords, P.O.	ed by the attending detached for use		HIV INFEC	TION; NARO	OTISM						10	Yes 22 No	3 Prof	bebly 4 Unknow
of Vital Records,	5 8 6										24a. Was	s an autopsy	24b. W	ere autopsy findings
00	should I	_										omed?	CO	ailable prior to impletion of cause death?
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Division	rs after death.	2	2 Accident 3 Suicide 4 Homicide	6 Could not	11/.	10/00 Injury - At h	nome, farm, streetify)	et, factory	, offica		28f. Location	(Street and Numi	ber or Rura	al Route Number,
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To the Hospital	within 24 hours after dealt. To the Funeral Director: completely filled in by the		9a. Certifier (Check only one)		hysician: To the be- miner: On the basis end manner	of examina								
Toth	To the comp		9b. Signeture and	title of certifier		1		290		e number		29d. Date signe		
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d item 2	3c per md G789 11/15/0	-		of Death		Reg. No.	36314
Physician /Medical	1. Decedent's Name (First, Middle, La DELGRES	ist)	KELL	1	2. Dete of Dea Month	Day BER 3, 20	Year (0'.45 PM
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	Usual Residence of Decedent 10a. Stete 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limits
tor	MD N	A Ba	altimore				MCXYes 2□No
Dire	10e. Street and Number		10f. Zip			10g. Citizen of W	haf Country?
by Funeral Director	2308 E. LaFaye 11. Marital Status 1 Never Married 20 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in U. Armed Forces? 1 Yes 3/2No If Yes, Give Yeer or Detes:	S. 13. Was Deced	ent of Hispanic Origin? (S ify Cuben, Mexican, Puerl No Specify:	specify Yes or No to Rican, etc.)	Black	- American Indien, c, White, etc. Black
-	15. Decedent's E (Specify only highest gn Elementery/Secondery (0-12) Unknown	ducation	16a. Decedent's Usua (Give kind of wor life. DO NOT us Supervis	k done during most of wo e retired)	rking	16b. Kind of Bu	ing Service
	17. Father's Name (First, Middle, Last Linwood	Fowlkes	Bupervis		me (First, Middle,		9)
	19a. Informent's Name/Relationship (Lauretta Stov 20a. Method of Disposition **D*Burial 2 Cremation 3 C 4 Donation 5 Other (Special Service Lices)	7 a l l Removal from Stafe (y) 20b. F	625 Linverse of Disposition (Name tens), crematory or	rood Avenu her of her place) emetery 11	e Balti Date -09-200	more, 20c. Location - 0	City or Town, State
	23a. Part1. Enter the disease, of corr	plications that caused the deat	WM.C.N	March FH 1	101 E.	North	Avenue
lan/Medical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. CEREB I Due to (c b. CARO Due to (c C. AS PI	RAL HYP or as a consequence of): RATON or as a consequence of):	OXEMIA			Seven hours
y Physician/M	Part II. Other significant conditions of	contributing to death but not res	ulting In the underlying ca	ause given in Part I.		lobacco use con Yes 2□ No	tribute to the cause of death? 3 Probably 4 Ninknown
Completed by						an autopsy med?	24b. Were autopsy findings available prior to completion of cause of death?
					10	/	1 □ Yes 2 □ NO
alloll. To be	25. Was case referred to medical examiner? 1 PYes 27. Manner of Death 1 Natural 5 Pending investigation	28a. Dete of Injury (Month, Day Year)	ER/Outpatient 3 DC 28b. Time of Injury M	Other:	F	dence 6 Other	ed
Certification:	3 Suicide 6 Could not be determined	building, etc. (Specif	y)		City or To	vn, State)	er or Rural Route Number,
Medical	(Check only 2 Medical Example)	nysician: To the best of my kno niner: On the basis of examine and manner stated.	tion end/or Investigetion,	In my opinion, deeth occi		date end place, e	and due to the cause(s)
	29b. Signetura end title of certifier	1 4		. License number			(Month, Dey, Year)
	30. Name and address of person who	completed cause of deeth (Item	n 23e) (Type, Print)	25-000	THORE		R 3,2000
state strar	31. Date filed (Month, Day, Year) NOV 1 5 2000	WER 110 DHNS 32. Registrar's Signa Server		STITL BAL	MORE	MARYLA	IND ZIZB7



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND#1 PER MD. G789 11-15-2000 JAB 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death KENDZIERSKI **EDMUND** WALTER Month Day Year 11:381 **Physician** Walter -dmund 12iecci 2000 November /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Death Examiner Hopdins Ba (timore Medical Dayorow Center 7. Aga (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. II. Data of Birth (Month, Day, Year)

Norths Days Hours Min. (Month, Day, Year)

Narch 12 1920 6. Social Security Number 6. Sex Birthplaca (Stete or Foreign Country) **Funeral** 10 M 20 F Director 218-10-9804 Maryland Usual Residence of Decedent 10c. City, Town or Location 10e. State 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? r hams 23s or 7 siner must be n 1902 Larkhall Road 21222 U.S. of America 12. Was Decedent Ever in U,S. Armed Forces? 1944
1 Xyas 2 No 1946
1 Yes, Giva 1946 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status 1 Nevar Married 2 Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 "natural", or SpecifyWhite by 3€ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within Hygiens. Elementary/Secondary (0-12) College (1-4or 5+) 10 Machinist NA American Can 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ahould be Mental marked Kendzierski John Helen Chojnacka and lam. 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Pages 1 and 2 s nant of Health an Department of Health a Important: If item 27 is any injury or other tra-Stanley Andrews (Step Son) 1902 Larkhall Rd. Dundalk, Maryland 21222 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition NOV. 1 Burial 2 Cremation 3 Ramoval from State Oak Lawn 15 Eastpoint, Maryland 4 Donation 5 Other (Specify) 22. Name and Addrass of Facility W. Dabrowski-Chojnacki F.H.'s P.A. 1005 Dundalk Ave. Balto., Md. 21224
That caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
e on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final ung Cucas months disaase or condition resulting in death) Examiner Due to (or as a consequence of) Examine attending physician end for use as the burial-transit certificata be executed Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or as a consequenca of): 23b. Did tobacco use contributs to the cause of death? P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the 2 1 Y88 2 No 3 Probably 4 Unknown g Division of Vital Records. 24b. Were sutopsy findings available prior to been sig 24a. Was an autopsy performed? Completed completion of cause of death? page 2 s 1 Yes 2 10 No 1 Yes 2 No certificate Physician: 25. Wes case referred to medical axaminar? Be 26. Place of Death (Check only one) Hospital: 1 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 2 ER/Outpatient 3 DOA this To the Hospital or Attanding Ph within 24 hours after death.

To the Funeral Director: Air-completely (III) 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Deeth 28c. Injury at Work? Certification: 5 Pending Investigation 1 Natural 1 Yas 2 No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stele) 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) 1 cutery

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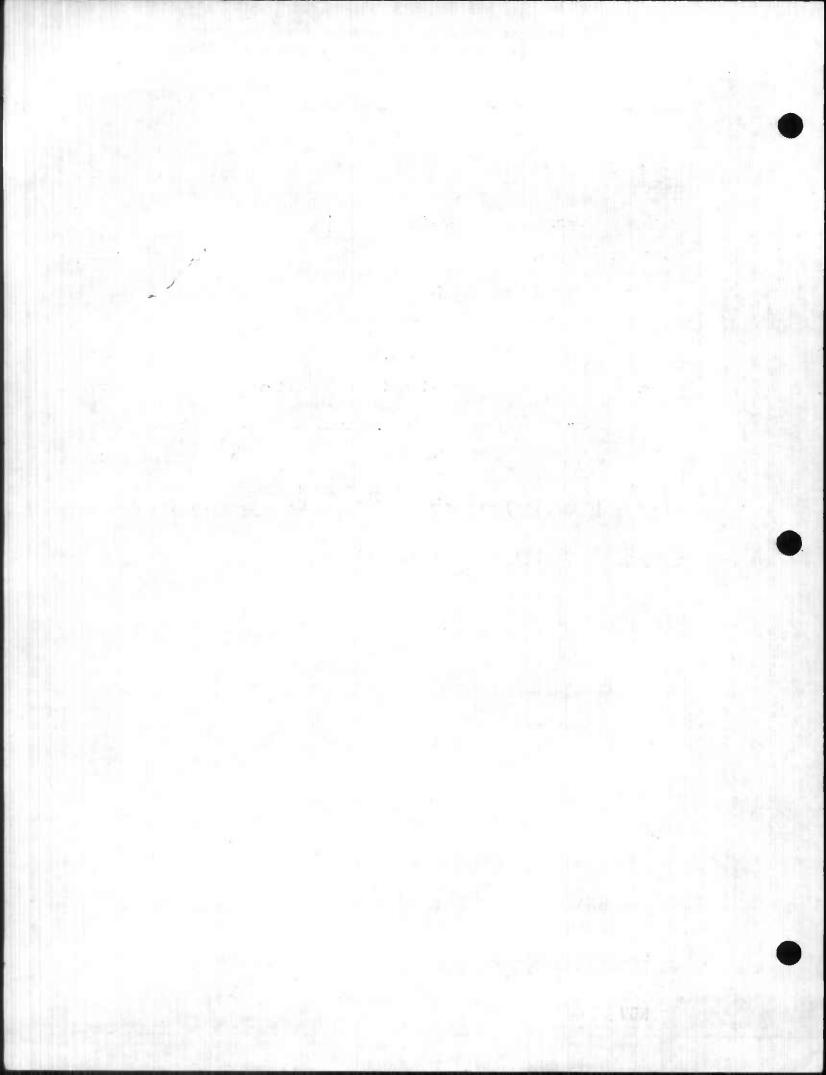
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32. Registraris Signatur

30. Name and address of person who completed cause of deeth (ttem 23e) (Type, Print)

brandes



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dev Month **Physician** 11:35 A.M November 13, 2000 EULAH B. LIPSCOMB 4a Facility Neme (If not institution, give street and I /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare Caton Manor Galtimore If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** Min. Months Days 94 Yrs. 10 M 20 F Hours Director 220-20-7313 **Usual Residence of Decedent** 10a. Stete 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f ehow edical Examiner must be notified at 10d. Inside City Limits 1 Yes 2 No Director BALTIMORE MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3330 WILKENS 21229 **AVENUE** Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 24☐ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Marital Status Black, White, etc. 1 Never Merried 2 Merried Specify: AFRICAN 1 Yes 200 Specify: by 3℃Widowed 4 Divorced AMERICAN Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 1 and 2 should be filed within Health end Mental Hygiene. em 27 la marked other than Elementery/Secondary (0-12) College (1-4or 5+) 6th NA DOMESTIC HOME 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) WW Be GARFIELD WILLIAMS 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAREY STREET BALTIMORE, MARYLAND 21217 (Name of Dete 20c. Location - City or Town, State or other DANIEL GROSS (STEP-SON) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 6 1 XBurial 2 Cremation 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) MT AUBURN CEMETERY 11/17/00 BALTIMORE, MD 21. Signature of Funeral Service License 22. Name and Address of Fecility WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cade on each line. Approximete Intervei Between Onset and Death **Physician** bleeding DAY. /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 250 3 Probably 4 Unknown TRIGEMINAL NEURALGIA þ 24b. Were autopsy tindings aveilable prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed 1 Yes 2 0 1 Yes 20 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2NNo Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation Netural To the Hospital or Atlanding within 24 hours after death. To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 117 Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier Julka

State Registrar

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Baltimore, Maryland

Box 68760

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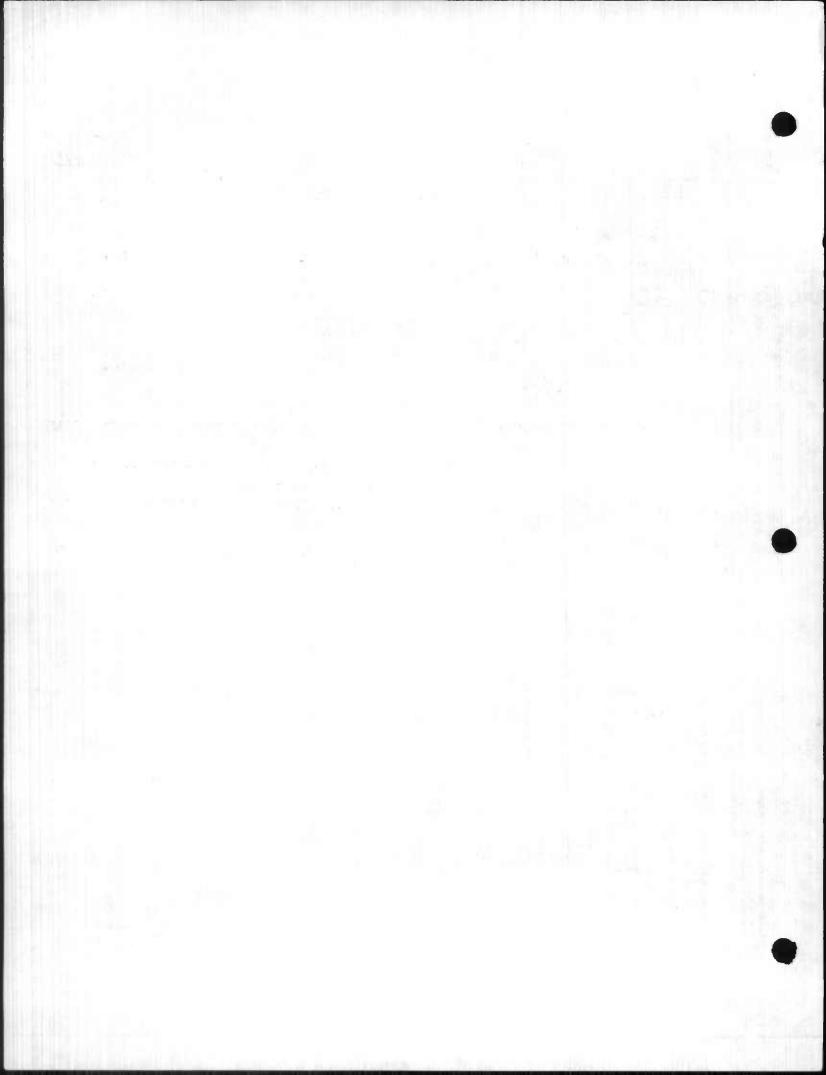
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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURTIT S JULKA M. D. 821N EUTAW ST, 32. Registrar's Signature

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BALTIMORE MD 2120/

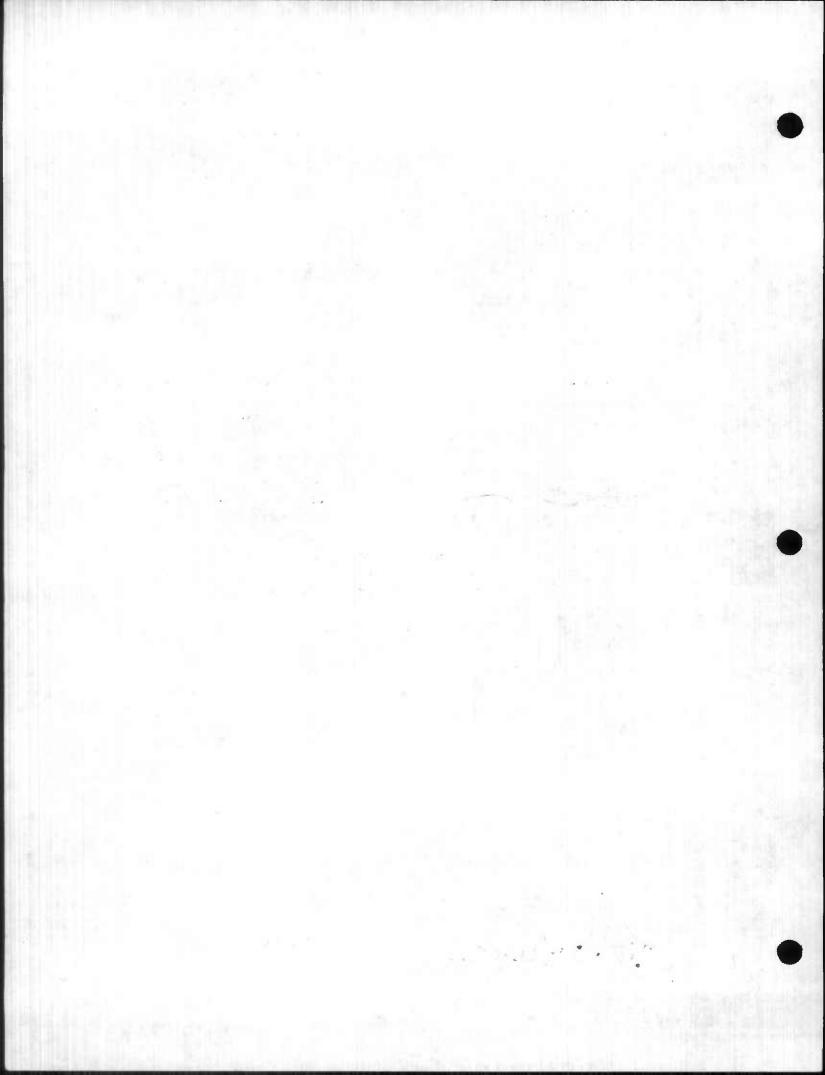


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State of Maryland / Department of Health and Mental Hygiene 0 363 17

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	Physicia	n	1. Decedent's Neme (First, Mid Cornelia Lu	dle, La								Dete of Death Month	Day	Year	3. Tima of Death
	/Medica Examine	ıl -	4e Facility Name (If not institut			r)				4b. City, Town		ovember	5, 20 4c. County		10:35am
	LAdmine		8503 Schultz I							Clint		D	Prin	ce G	eorges
	Funeral Director		5. Social Security Number 503 44 4152	6. 5	Sex 7. A	ge (In yrs. 90	last birthday Yrs.	Month:	er 1 Yeer S Deys	If Under 24 Hours	Min.	Dete of Birth (Month, Day,) arch 5,		9. Birthp Coun	elace (State or Foreign etry) SD
	rland rand	-	Usual Residence of Decedent 10a. Stete 10b. Coun	ty		10c, Cit	ty, Town or I	Location						1	Od. Inside City Limits
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1	\$ 7		30. Name and address of person Robert B. D	on who	completed cluse of				row	Medic	al C	enter	, Cli	nton	Maryland
	State Registra		31. Dete filed (Month, Day, Year NOV 1 5 2000	10	32. Regis	trer's Signa		the!		Y		41 M			

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. AMEND ITEM: 26 PER PHY G790 12-1-00 WR. of Maryland / Department of Health and Mental Hygiene Certificate of Death amend item 1 per md G789 11/15/00 yf Reg. No. Ocie Pearl Mitchell 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 11:16 AM OCTOBER 2000 24 /Medical 4a Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CITY GOOD SAMARITAN HOSPITAL If Under 1 Yeer | If Under 24 Hrs. | 8. Date of Birth | Worth, Day, Year 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 KF 92 234-10-0a27 Yrs. OCTOBER 3, 1908 WEST VIRGINIA Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show MARYLAND N/A BALTIMORE 1 Yes 2 No Directo r than "natural", or thems 23s or 28s-f the Medical Examiner must be notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES OF HIMERICA NORTHERN PARKWAY 21214 2901 EAST Funeral 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE þ 3 ₩Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) SEAMSTRESS Hyd 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ould be Mental BRAGE is marked VIRGINIA GRIMM JAMES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an permit. Pages 1 and 2 Separtment of Health a Preportant: If them 27 is any injury or other trau page. 2901 EAST NORTHERN PARKWAY BALTIMORE, MD. 21214 JUSTINE U. NELSON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stefe 20a. Method of Disposition 1 🗷 Burial 2 Cremation 3 Removal from State BRICK CHURCH CEMETERY OCT. 27,2000 LOST CREEK, WEST VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) 6009 HARFORD ROAD 21. Signature of Funaral Service Licensea 22. Name and Address of Facility ALTENBURG FUNERAL HOME, P.A. BALTIMORE MD. 21214 Honald R. 1.#M00612 Watson, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onset and Death **Physician** immediate Cause (Final disease or condition resulting in daath) /Medical CURUNAM 1791 Examiner Dua to (or as a consequence of): Physician/Medical Examiner The lew requires that the death certificete be executed been signed by the attending physician and should be deteched for use as the burial-tran-Sequentially list conditions, if any, leading to immediata causa. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 68760 Due to (or as a consequenca of): Box (P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes ZNo 3 Probably 4 Unknown heart Failure of Vital Records. by 24b. Wara autopsy findings available prior to completion of cause of daath? certificate has been si irector, page 2 should I 24a. Was an autopsy performed? Completed Diabetes 1 Yes ZUNO 1 Yas 2 No Physician: funeral director, 25. Was case rafarred to medical examiner? Be 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Amesidenca 6 Other (Specify) 1 Yes 2 No Medicai Certification: To After this 28a. Date of injury (Month, Day Year) 28d. Describe how injury occurred 27. Mannar of Death 28b. Tima of Injury 28c. Injury at Work? spital or Attending P nours after death. neral Director: After t filled in by the funera Division 5 Pending investigation Natural t ☐ Yes 2 ☐ No 2 Accidant 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and placa, and due to the cause(s) and menner stated. 29a. Certifier 29c. Licensa number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar

Registrar UCT 2 6 2000



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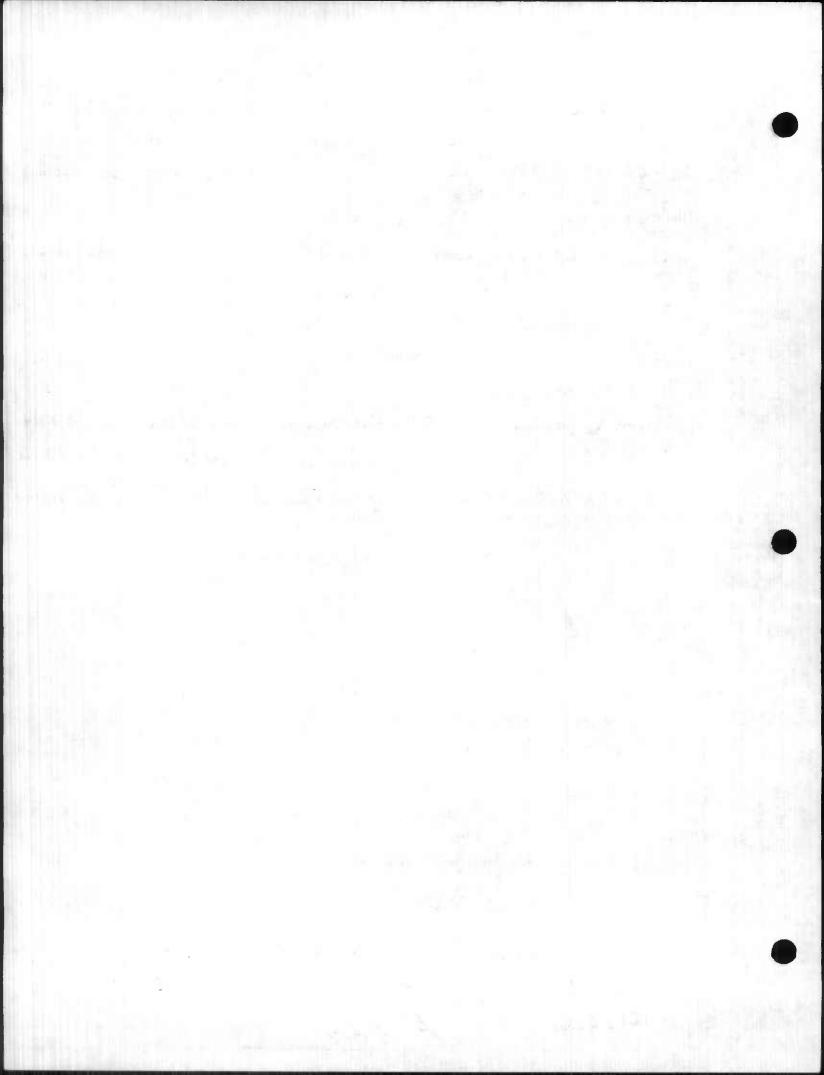
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30. Name and address of person who completed cause of death (Item 23a) (Type, Popt)

Low mo

Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Tima of Death 1. Decedent's Nama (First Middle Last) LAGUITE Michael A Facility Name (If not institution, give street and number) JOL 2000 4c. County of Death 4b. City, Town, or Location of Death BroRK 36 KOA Bridge Aure If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1⊠M 2□ F Months Days 218-80-8843 Yrs 41 Dec 25, MASS Usual Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Laurel 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8436 Rock Ridge Road 20724 USA 12. Was Decedent Ever in U.S. Armad Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American indian Black, White, etc. 1 Naver Married 2 ☐ Married 1 Yes 2 No Specify: white 3 Widowed 4 Divorced 16b. Kind of Businass/Industry unk 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) unk Elementery/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Francis M. Maguire Priscilla E. Peterson 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Priscilla Maguire/mother 16215 Julie Lane Laurel, MD 20707 20b. Placa of Disposition (Name of cematery, cramatory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 BOther (Spacify) In State State Anatomy Board Wades 655 W. Baltimore Street Director Wall Baltimore, MD 21201 29a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last Due to (or as a consequenca of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco usa contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Plece of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

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MD

Director

Funeral

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Capartment of Hearth and
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Baltimore, Maryland 21215-0020

end I-transit physician e 98 use for signed by t page 2

certificate hes this funeral After

Examiner

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29a. Certifier

31. Dete filed (Month, Day, Yeer)

NOV 1 5 2000

certificate be execu P.O. Box 68760, Physician/Medical Records, Completed Division of Vital Be To Certification: Attending efter death. Director: Af 3 ò filled in Hospital 24 hours Medical

> State Registrar

25. Was case referred to medical exeminer?

1 X Yes 2 No Hospitel: Other: 4 Nursing Home 5 Besidenca 6 □Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28d. Describe how Injury occurred 28h Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Netural 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifian Deput D00054

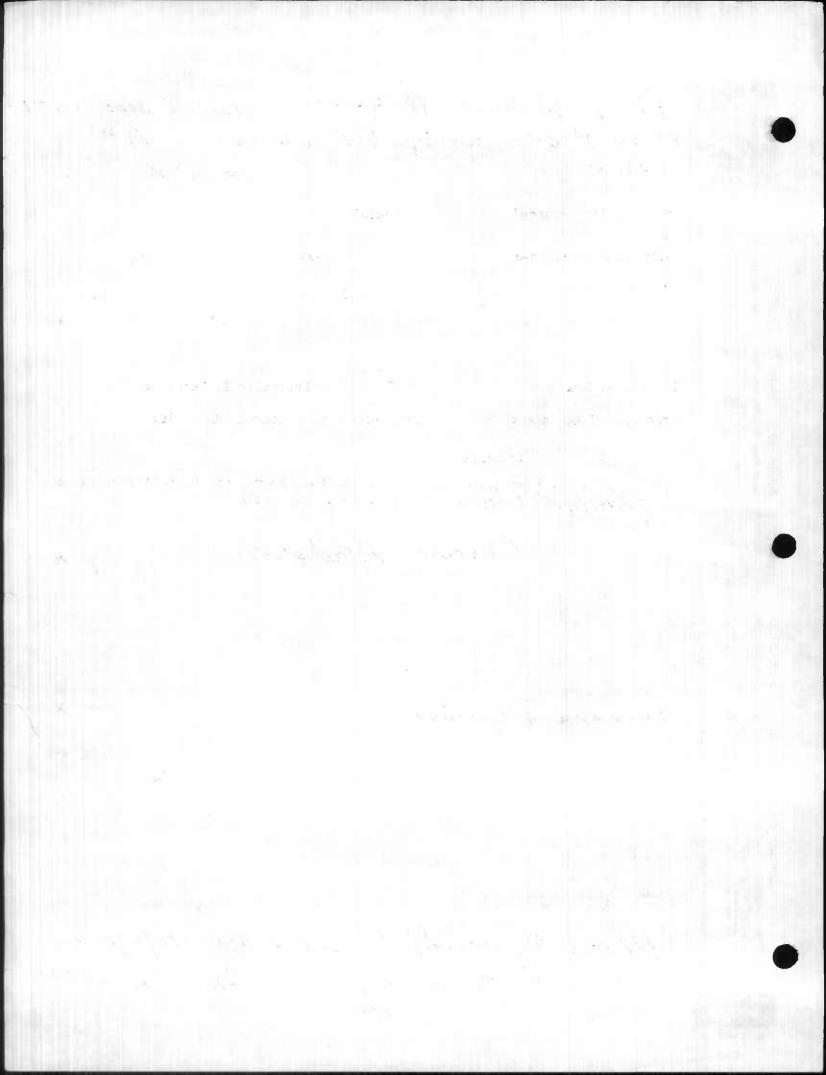
29d. Data sigged (Month, Day, Year)

use of death (Item 23a) (Type, Print) ess of person who con iAm

Jones 32. Registrar's Signature

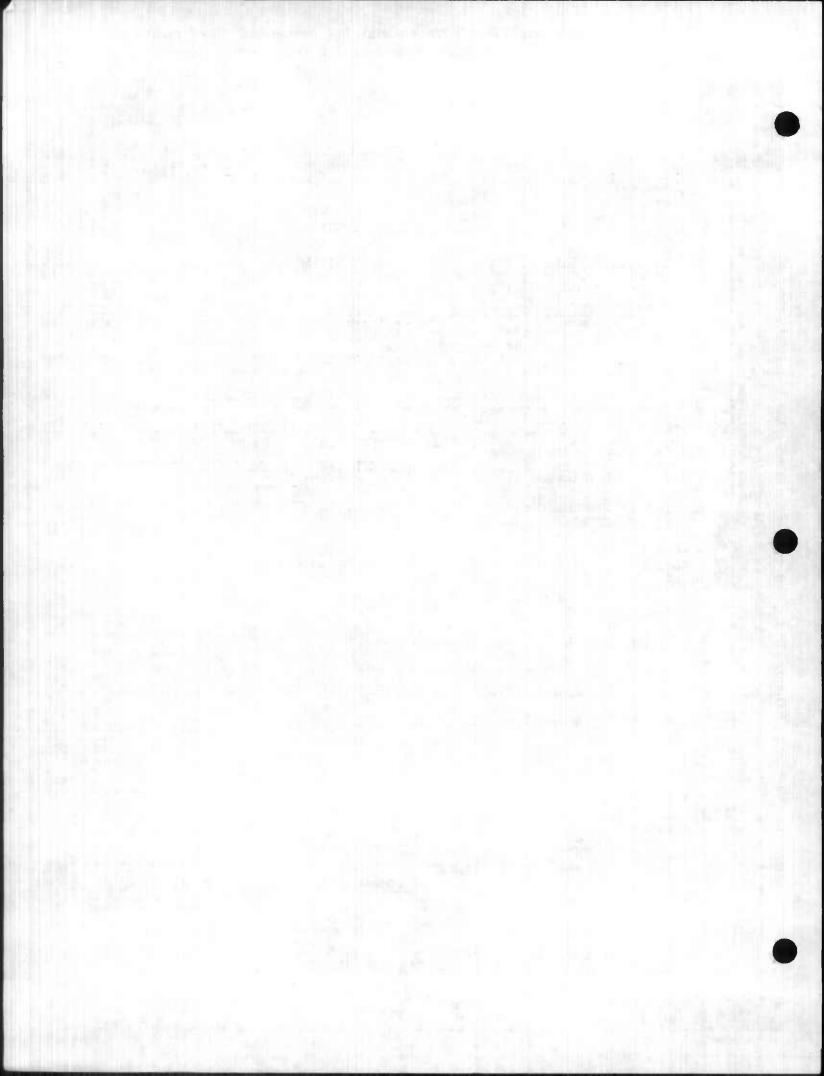
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Phys /Me	dical	1. Decedent's Name (First, Middle, Last) SALIM 4a Facility Name (If not institution, give stree	ENSE	a H		4b. City, Town, or U	2. Date of Deat Month Novembe	Dey Yee	0 1:50PM		
Exam Funera Directo	al .	Bon SECOUL 5. Social Security Number 6. Sex 214-94-3819	7. Age	OSPITA o (In yrs. last birthdi 36 Yrs	ey) If Under 1	BALTIMO		NA	irthplace (State or Foreign Country)		
2		Usual Residence of Decedent 10a. Stete 10b. County		10c. City, Town or	r Location				10d. Inside City Limits 1 ₺ Yes 2 □ No		
ier death with the Maryland Nems 23a or 28a-f ahow ner mast be motified as	Funeral Director	MD NA 10e. Street and Number		Day 8	BALTT 101. Zip (Code	11	Og. Citizen of Whet (Country?		
_ 5 22	by	1 Never Married 2 Merried	Wes Decedent I Armed Forces? I Yes ANA If Yes, Give Year or Detes:	Ever in U,S. 1	13. Wes Decede If Yes, speci	21216 ent of Hispenic Origin? (Si fy Cuben, Mexican, Puerto X No Specify:	pecify Yes or No- p Rican, etc.)	Bleck, Wr Specify: A F	nerican Indien, nite, etc. RICAN		
21215-0020 d within 72 hours af piene. rr than "natural", or the man "natural", or the m	Completed	15. Decedent's Education (Specify only highest grade contentary/Secondary (0-12)	on <i>mpleted)</i> College (1-4or 5	16a. De (G iif	ecedent's Usuei live kind of work e. DO NOT use	Occupation done during most of work retired)	king	16b. Kind ot Busines	s/Industry		
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MOFE, Peges 1 a ent of Hei mt: If Nem ry or othe		20e, Method of Disposition M Buriel 2 □ Cremetion 3 □ Remodel 1 □ Donetion 5 □ Other (Specify)		e of her plece)	Date	RANDALLST	or Town, Stete				
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To the Hoeptal or Att within 24 hours after of To the Funeral Direct completely filled in by	edical (examinetion and/o		It the time, dete end plece in my opinion, deeth occu					
To the Top	M	29b. Signature end title of certifier.	er 1	4. D		License number D 47804	2	9d. Date signed (Md	onth, Day, Year) 2000		
5		30. Neme and address of person who complete A - MRD W115 C B	eted cause of de	eeth (Item 23a) (Ty Lovy Ho,	pe, Print)	West Bult	inove th	2022	Balh'more		
S Regi:	tate strar	NUV 1 5 2000	32. Registre	er's Signature	rakst						

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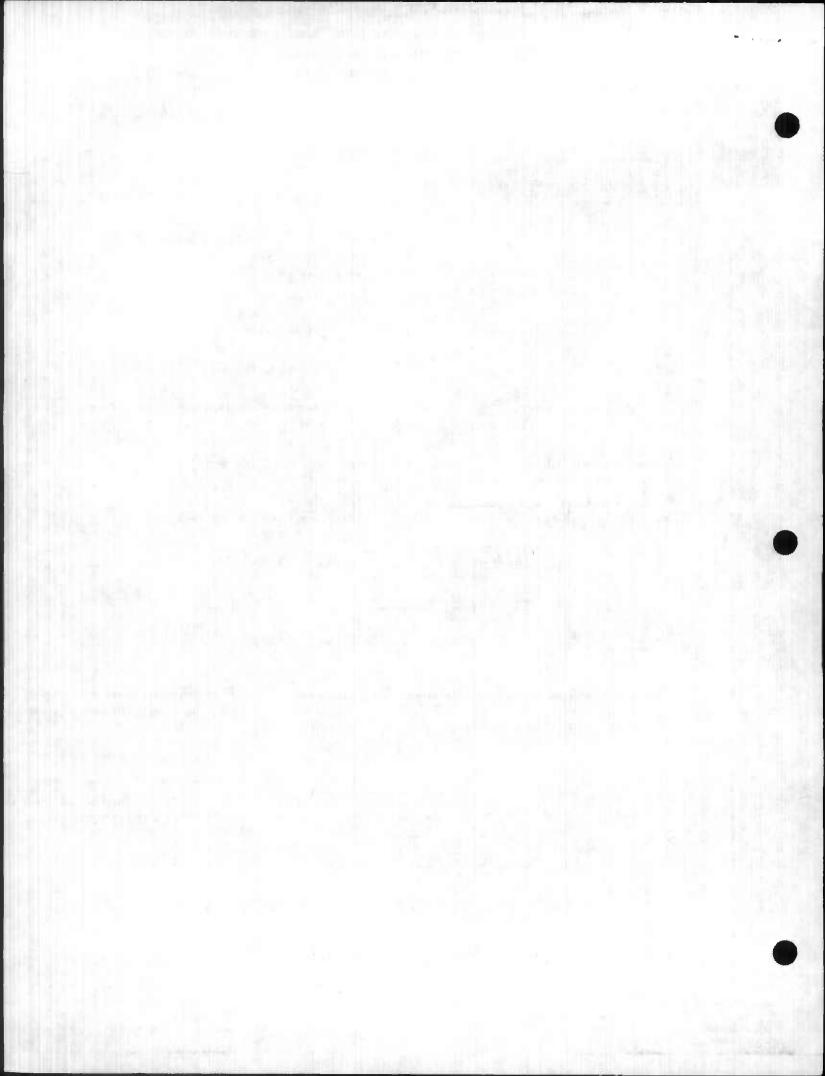


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State of Maryland / Department of Health and Mental Hygiene 36321

				Cei	rtificate	of Dea	th		Reg. No.	0 00021
	1. Decedent's Name (First, Mid	die, Last)						2. Date of De		3. Tima of Death
Physician	James	McCle	ellan,	.Tr				NOVEM	1=0 12	2000 002 5AI
/Medical	4a Facility Nama (If not instituti			UL.		4b. City	, Town, or L	ocation of Deat		
Examiner	Stella Mari			су		Bal	timo	re	1	1A
Funeral	5. Social Security Number	6. Sex 7	. Age (In yrs. la	st birthday)	If Under 1 Y		nder 24 Hrs.	8. Date of Bir (Month, Da	th	9. Birthplace (State or Foreig
Director	214-14-1623	XXM 2□ F	78	Yrs.	Months D	ays Ho	urs Min.	08-2		Country) NC
	Usual Residence of Decedent		70					100-2	1-7.7	NC
E SH	10a. Stata 10b. Coun	ly	10c. City,	Town or Lo	ocation					10d. fnslde City Limit
Man Had hor tor	MD	NA	Bal	timo	re					1X Yes 2 No
or 288-4 or notified	10e. Street and Number			F-0.7	10f. Zip Co	ie			10g. Citizen of V	What Country?
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here 23e or 28e-f sho her must be notified at unersi Director	11. Marital Status	Armed Fore	ces?	13.	ff Yes, specify	Cuben, Me	xican, Puert	pecify Yes or No o Rican, etc.)	Blac	ck, Whita, etc.
y F	1 Never Married 2 Ma	If Yes Give			1□ Yes 2□	No Spe	city:		/ D11-	
D D	3 Widowed 4 Divorce		tes:						Black	
dica disa	15. Decede (Specify only high	ent's Education last grade completed)		16a. Deced (Give	dent's Usual O kind of work d DO NOT use n	one during	most of wor	king	16b. Kind of Br	usiness/Industry
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Compl	High Sch.Gr			Mach	ine Or			Miles I	Revee	
9	17. Father's Name (First, Middle	e, Last)				18. N	lother's Nam	ne (First, Middle	, Maiden Suman	10)
To E	James M	cClellan,	Sr.			Be	atri	ce	McC.	lellan
-	19e. Informant's Neme/Reletion	nship (Type, Print)	TO TO	19b. Meitir	ng Address (Si	reet and N	um <i>ber</i> or Ru	ral Route Numb	er, City or Town,	State, Zip Code)
	Linda V.	McClellan		1543	4 Arbo	ory W	lay L	aurel,	Maryla	nd 20707
E 60	20a. Method of Disposition		20b. Pla	ca of Dispo	osition (Name	of .		Date	20c. Location -	City or Town, State MD.
= 8	t Burlal 2 □ Cremation		ISIA		matory or other		1/1	11	17 200	
12	4 Donation 5 Other		Ga							00 Owings Mi
ny ic	21. Signature of Funeral Service	e Licensee		22	2. Name end A	ddress of F	Ba	ltimor	e, Mary	land 21202
	1 Dland	p Wan		W	M.C.Ma	arch	FH 1	101 E.	North	Avenue
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should								24e. Was	an autopsy ormed?	24b. Were eutopsy findings available prior to
page 2 should								pun	oimog i	completion of cause of death?
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director,	25. Was case referred to medic examiner?	Hospital:					Plece of Dea	ath (Check only		MARIS AT ME
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funeral funeral	27. Manner of Death	ling 28a. Date of	Injury Day Year)	28b. Time o Injury	if 28c.	fnjury at Work?		28d. Describe	how injury occur	red /
the fu	2 ☐ Accident inves	tigation			М	1 Yes	2 🗆 No			
in by the fune	3 Suicide 6 Coul 4 Homicide dete	d not be mined 28e. Place	of Injury - At hong, etc. (Specify)	ne, farm, str	reet, factory, of	fice		28f. Location	Street and Numi wn, State)	ber or Rural Route Number,
	4 Differences	Dandir	g, etc. (opecity)					Only or 10	wii, Giaio,	
	29e. Certifier 4 Certify	ing Physician: To the b	pest of my know	ledge, deeti	h occurred et ti	ne time, de	te and plece	, end due to tha	cause(s) and m	anner es stated
plantsly filled edical C			sis of examination							and due to the ceuse(s)
Med	29b. Signature and title of certif				29c 1 i	cense num	ber		29d. Date sinne	d (Month, Day, Year)
19/		~			7	110	974			
1	50	0 1)		D	703	50/		VOUEML	XER 13,2000
MX	30, Nama and address of person	n who completed cause	of death (ttem	23a) (Type,	Print)	1 1	1	2-11	1 ma	ER 13,2000
1	LAUID KIS	EDERG	301	5	+ PAU	1 11		DAH	1110 RX	= 11/4 2/782
State	31. Date filed (Month, Day, Yea	r) 32. Re	glstrar's Signatu	Ire						
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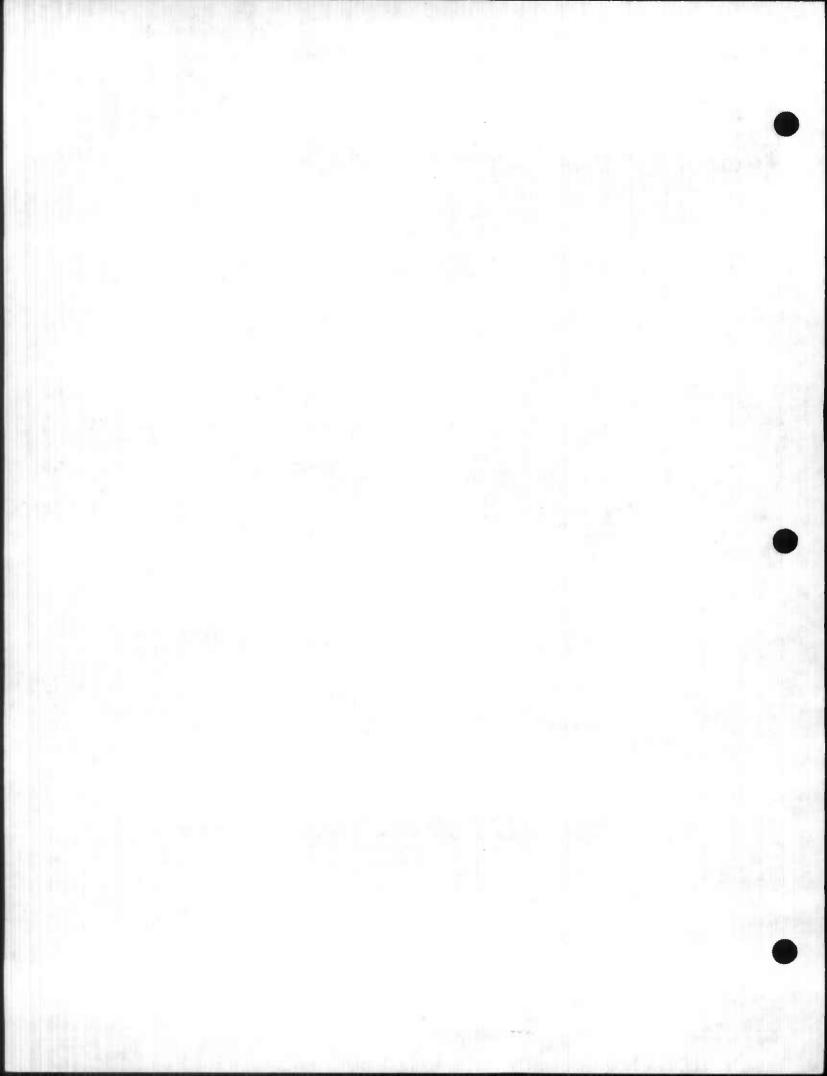
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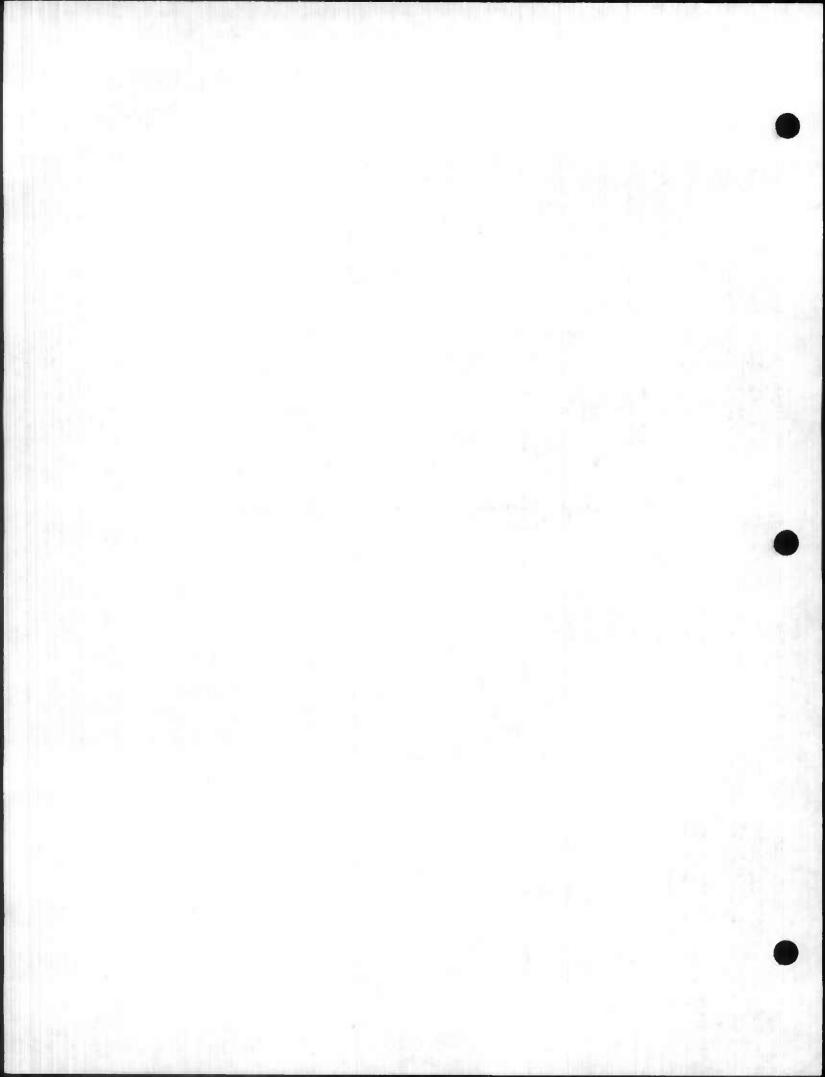
an					ate of Death		Reg. No.			
	1. Decedent's Nama (First, Middle, i	Last)				2. Data of t	Death Day	3. Time of Deeth		
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	University of M	aryland Med	lical (Center	Balt	imore	N/A	A		
C	5. Social Security Number 219 - 80 - 9023		e (In yrs. lest		dar 1 Yaar If Undar 24 ns Deys Hours			9. Birthplace (State or Foreign Country) MARY LAND		
-	Usuel Residence of Decedent 10a. Stete 10b. County		10c. City, T	own or Location				10d. Inside City Limit		
runeral Director	MARULAN 1	1/4		BA	LTIHORE	: CIT	1/	1⊠Yes 2□N		
Y	10e. Street and Number	0//1		101.	Zip Code		10g. Citizen of V	Whet Country?		
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F	15. Decedent's	Education	1	6e. Decedent's U	suel Occupation	Lungking	16b. Kind of Bu	usiness/Industry		
-	(Specify only highest (Elementary/Secondary (0-12)	College (1-4or !	5+)	life. DO NOT	work done during most of usa retired)	working				
	9 THGRADE		1	INKNOWN			UNKNOU			
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	19e. Informent's Neme/Relationship			19b. Mailing Addre	ess (Street end Number	1 1		4 1 4		
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4 Donetion 5 Other (Specify) MT. 7 ION (FMFTFR V 11-21-00 LANSDAWER A										
	22. Neme and Address of Facility BROWN JR, FUNERAL H									
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	F 3 F 8		101	Lal	0 . 14	0			0.	.C.	.M.E.		Novembe	r 08.	2000)	
		-	30. Name end address of person who completed cause of death (Item 23e) (Type, Print)														
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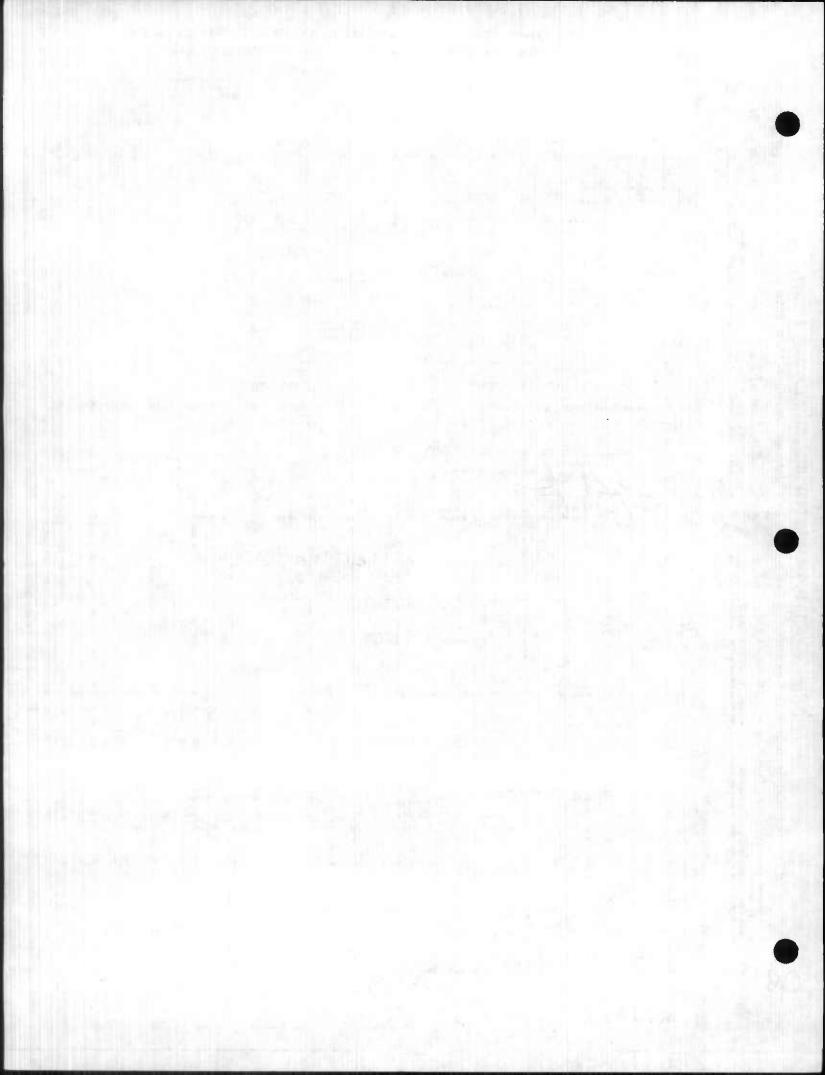
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State of Maryland / Department of Health and Mental Hygiene 0 36321

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The state of the s	phys s the	resulting In death) Lest	Due to (or	es e consequer	ice of):				1	
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24a. Wes an autopsy performed? 24a. Wes an autopsy performed? 25. Was case referred to medical examiner? 1 Yes 20 No	O the def	Part II. Other significant conditions con	tributing to death but not resu	iting in the unde	rhying cause gi	iven in Part I.				
29a. Certifier (Check only one) 29medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) 40 20 5 19 26 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)	= = 00						1981	00 2□NO 3	Probably	UOnk
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B-15 Helen M. Gordan 6601 North Charles St. Bathmore MD 21204	plant of the land	200 Carillian STA a sure to a	John To the best of	dodas de ti		less data serials	and don to the	in and and and		
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State 31. Date filed (Month, Dey, Year) 32. Registrer's Signature	La Com	31. Date filed (Month, Dey, Year)				3 7, 13	Claraic	Me Me	212	7



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

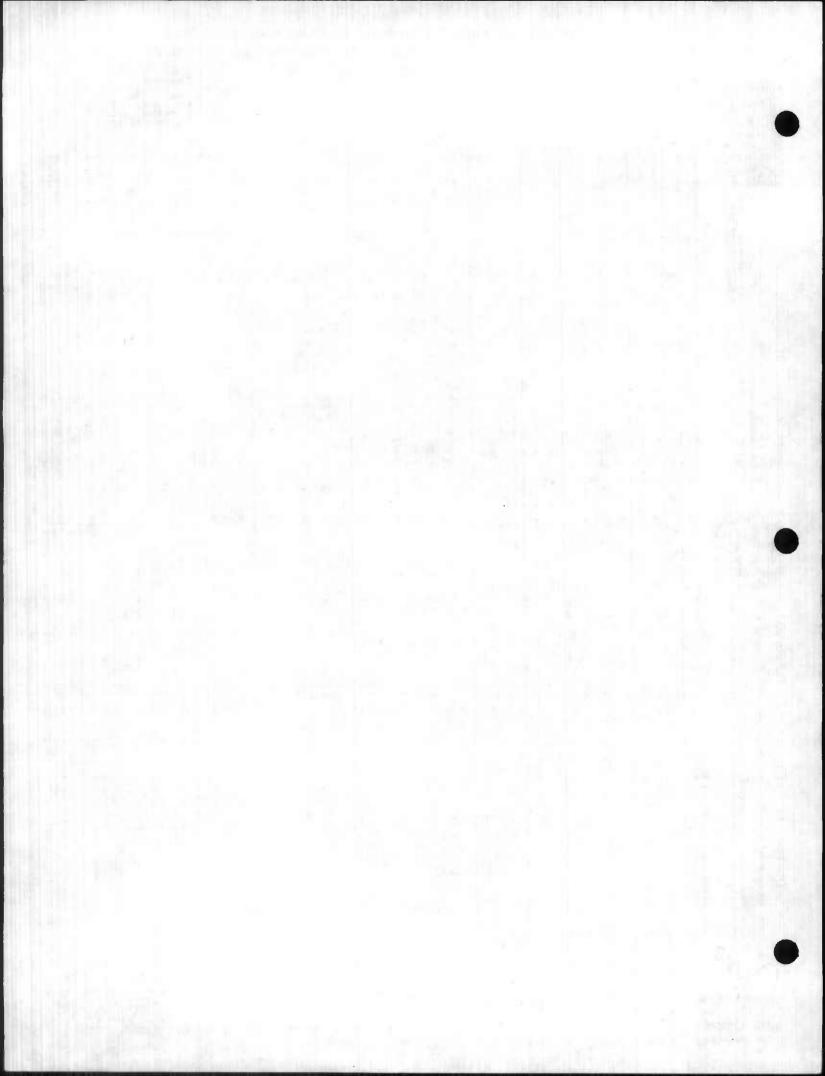
			Ocitino	ate or	Death		Heg. No.	
Physician	Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	3. Time of Death
/Medical	VIRGINIA M. M	CCORMICK				Novemb	-	2000 12:24am
Examiner				1	4b. City, Town, or I	_ocation of Death	4c. County	of Death
	Greater Baltimore			der 1 Year	TOWSON If Under 24 Hrs.	Dott of Bird		imore
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. la		hs Days	Hours Min.	(Month, Da	y, Year)	Birthplace (State or Foreign Country)
Director	Usual Residence of Decedent	91				07-29-	-1909	MARYLAND
9 Bu	10a. State 10b. County	10c. City	, Town or Location			124		10d. Insida City Limits
Mary 14 ab	MD. BALTIMORE	4	ELKRIDG	E ES	STATES			1 ☐ Yes XX No
with the Maryla t or 28e-f show be notified at	10e. Street and Number		10f.	Zip Code			10g. Citizen of V	Vhal Country?
and	10 OVERRIDGE COU	RT			21210		υ.	S.A.
dead dead	11. Merital Status 12. Wes	Decedent Ever in U.S	5. 13. Was De	ecedent of I	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No		a - American Indian,
S at the state of	1 Never Married 2 Merried 1	ed Forces?				o Hican, etc.)		k, White, etc.
DO OS	XXWidowed 4 Divorced Year	s, Give or Dates:	1 Ve	S AM NO	Specify:		Specify	WHITE
215-0036 thin 72 hours at an "natural", or Medical Exam	15. Decedent's Education (Specify only highest grade comple	stadi	16a. Decedent's U	Isual Occup	pation during most of wor	kina	16b. Kind of Bu	sinass/Industry
21 man 10		nge (1-4or 5+)	life. DO NO	T use retire	d)	n.i.y		
22 Marie 2		ARS	SE	CRETA				DICAL
D STORE S	17. Father's Name (First, Middle, Last)	TTTDD			18. Mothar's Nan			
New Man		ILLER	1153		VIRG		. MUR	
Age 2 sty	19a. Informant's Name/Relationship (Type, Print				end Number or Ru		1000	
and and mark	ANN M. SOMERVILLE		106 ELI		ST ROAD,			D.,21210
O SE PER PO	20a. Method of Disposition XX Burial 2 □ Cremation 3 □ Removal 6	Irom State C6	emetery, cremetory	or other ple		Date		City or Town, State
times part	4 □ Donation 5 □ Other (Specify)	TO.	RRAINE			1-15	MOODLA	WN, MD. 21207
Sal separation named in the separation in the se	21. Signature of Funeral Service Licensee				JENKINS	S AND S	ONS CO	MPANY
W 705 8 9	R. J. Kuth							YLAND, 21212
	23a. Part1. Enler the disease, or complications t shock, or heart failure. List only one cause	hat caused the death on each line.	. Do not enter the	node of dyi	ng, such as cardiad	or respiretory e	rest,	Approximate Interval Between
Physician		01						Onsat and Death
/Medical	Immediate Cause (Final disease or condition	Cande	an au	م	+			min.
Examiner	resulting in death)	Due to (or	as a consequence	ot):				
2 = 5		en C	allen	- 01	the an	-12	inke	In Days
owecuted n and tel-transit	Sequentially list conditions,	Dua to (or	as a consequence	ot):	0		- 1	
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68760, ficate be en physician as the buria	that initiated events rasulting in death) Last	Due lo (or	es e consequence	of):				1
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O a the	Part II. Other algnificant conditions contributing	to death but not rasu	lting in the underlyi	ng causa gi	van in Part I.	23b. Did	tobacco usa con	ntribute to the cause of death?
P deta		. ((_	_			10	Yaa 2□ No	3 Probably 4 Unknown
0 8 58 6						24n Was	an autopsy	24b. Ware autopsy findings
The law requires The law requires The law requires page 2 should be	Sem Pc	10					med?	available prior to completion of cause
Pec e law hes b	6.0 1	- 0	0				-	ot death?
= F # 8 0)// ac a		15410	w.		10	Yes 2 No	1 ☐ Yes 2 ☐ No
Vitai I belclen: The certificate lirector, page Co	evaminer?	/	1.	100	and the second second	ath (Check only o	one)	
The state of				DUA		lome 5 ☐ Rasi		
After funer	27. Mannar Death 1 Natural 5 Pending	Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Inju Wo		28d. Describe	how injury occur	red
Attending or death. octor: Afte by the fune	2 Accident investigation 3 Suicide 6 Could not be	21	M		Yas 2 No	29f Location (Street and Numb	ers or Pural Pouts Number
DIVISION or attending P as the redeath. The division of the funer led in by the funer Certification:	4 Homicida determined 28e.	Placa of Injury - At hor ouilding, atc. (Specify,		HOTY, Office		City or To	vn, Stata)	er or Rural Route Number,
Hospital 24 hours a Funeral II stely filled		n the heat of my bran	uladaa daath cocu	rad at the st	me data and alas-	and due to the	causa(s) and ma	unner as stated
he Hospi in 24 hou he Funer pletely fil	29a. Certifier 1 Certifying Physician: To (Check only one) 2 Medical Examiner: On tand							
DIVI To the Hospital or At within 24 hours after of completely filled in by Medical Certifil		and states.		29c. Licen	se number		29d. Dale signe	d (Month, Day, Year)
8484	1000	as	>	n	nun	121	11/1	12/00)
2010	20 Name and addison of	coupe of death (h)	02a) (Time Dian)	UZ	270	141		400
A	30, Name and address of person who completed	cause of death (riem	Zoa) (Type, Pint)	41	11	20	ROI	

State Registrar

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Certificate of Death Reg. No.					
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State of Maryland / Department of Health and Mental Hygiene	00	21	-	2	6
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	Certificate of Death	Reg. No.
Physician	1. Decedent's Nama (First, Middla, Last)	2. Dete of Death Month Dey Year 2. Time of Deeth
/Medical	JANNIE BELLE NIXON 4a Fecility Name (If not institution, give street and number) 4b. City, Town	y or Location of Death 4c. County of Death
Examiner	Maryland General Hospital Partin	nore CVY N/A
Funeral	5. Social Seburity Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Months Days Hours	
Director	220-14-1548 1D M XXF 86 Yrs. Months Days Hours	DECEMBER 20 1913 CAROLINA
/land	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
the Marylar 28a-f ahow northed at	MARYLAND N/A BALTIMORE	1XX as 2 □ No
€ 8 8	10e. Street and Number 10f. Zip Code	10g. Citizen of Whet Country?
filer death w	2529 EDMONDSON AVENUE 21223 11. Marital Stetus 12. Was Decedent Ever in U.S. 13. Wes Decedent of Hispanic Origin	U.S.A. 17 (Specify Yes or No- 14. Race - American Indian,
020 urs after al., or its	11. Marital Stetus 1 ☐ Nevar Married 2 ☐ Merried 3 ⚠ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No Specify: 1 ☐ Yes 2 ☒ No Specify:	Bleck, White, etc. Specify: BLACK
1 21215-0020 led within 72 hours at Nyleine then "partnell", or har then "part	15. Decedent's Education 16a. Decedent's Usuel Occupation (Specify only highest grade completed) (Give kind of work done during most o	f working 16b. Kind of Business/Industry
2121 4 within plene. r than rrs the	Elementery/Secondery (0-12) College (1-4or 5+)	FOOD CARE
C BELL O	oth grade	Name (First, Middle, Maiden Surneme)
Aaryland 212. 2 should be filed within and Mantel Hygiene. In marked other than aumstic avant, the M. To Be Comp	GEORGE JACKSON ALBI	ERTA PINKNEY
	19e. tnforment's Neme/Reletionship (<i>Type, Print</i>) 19b. Meiling Address (<i>Street</i> end <i>Number</i> of the street of t	or Rurel Route Number, City or Town, State, Zip Code)
	Costella D. Jackson/Niece 2529 Edmondson Ave	enue, Baltimore, Maryalnd 21223
2 2 2 2 2	VXBuriel 2 ☐ Cramation 3 ☐ Removel from State cematery, crametory or other plece)	
Baltimo	21. Signature of Funeral Service dispenses 22. Name end Address of Facility	11-17-00 BALTIMORE, MARYLAND
W See See See See See See See See See Se	PLOULIN 1206 W NORTH AVE	COMMUNITY FUNERAL HOME PA
	23a. Pand. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cashock, or heart feiture. List only one cause on each line.	ardiec or respiretory arrest, Approximete Interval Between
Physician /Medical	Immediate Cause (Finel	Onset end Deeth
- Examiner	Immediate Cause (Finel disease or condition resulting in deeth) e. Up3/5 Due to (or as a consequence of):	
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68760, ificate be exe ophysician as the burial-ledical Ex	Cause (Disease or Injury	
	resulting in death) Last Due to (or as a consequence of):	
Box attendin for use	d	
the des	Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did tobecco use contribute to the cause of death?
IS, P.O. es that the de igned by the be detached by Physic	Acuk Kenal Failure	1 Yes 2 No 3 Probably 4 4 Inknown
ord requir		24a. Was an eutopsy performed? 24b. Were autopsy tindings available prior to completion of causa of death?
The law ate hes be page 2 s		1 Yes 2 No 1 Yes 2 No
Vital Inden: The certificate rector, page Co	avemine/?	Deeth (Check only one)
7 4 8 5 T	1 ☐ Yes 200 No Hospitel: 1 12 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nurs	ing Home 5 Residence 6 Other (Specify)
E & 55 P	27. Menner of Deeth 1 Netural 5 Pending (Month, Dey Year) 28b. Time of linjury 28b. Time of linjury 4 Work? 2 Accident Invastigation 28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred
Division C To the Hospital or Attending P within 24 hours after death completely filled in by the funers Medical Certification:	3 Suicide 4 Homlcide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)	281. Location (Street end Number or Rural Route Number, City or Town, Stete)
To the Hospital within 24 hours a within 24 hours a Completely filled	29a. Certifier (Check only Certifying Physician: To the best of my knowledge, deeth occurred at tha tima, date and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth	occurred at the time date and place and due to the several
the He He He Thin 24 mplets	one) end menner steted.	29d. Data signed (Month, Dey, Year)
5 × 5 8	29b. Signatura and title of certifier 29c. License number	\$ \$\frac{\ll \ll 3 \ll 0}{\ll \ll \ll 3 \ll 0}\$
(M)	30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)	/ /
W	JAMES E. mathew, m.D. To massiland (40	neral Kospital
State	31. Date filed (Month, Day Maar)	

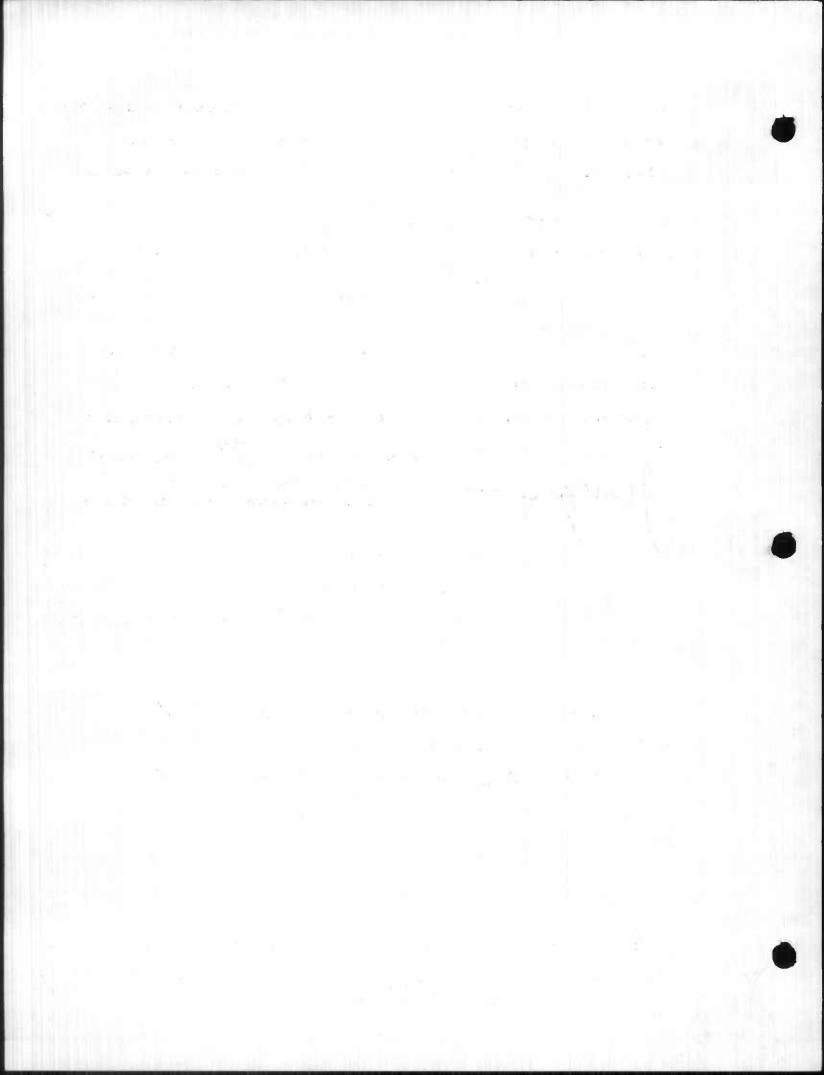


State of Maryland / Department of Health and Mental Hygiene 11 36327

					Cei	rtificat	e of	Death			Reg. No.		, ,	002	. 1
		1. Decedent's Name (First, Mi	ddle, Last)							2. Date of De	ath			3. Tima of	Death
	Physician	Orville Rebe	ecca Nims							Novem	Day ber 1		Year 2000	3:45	p.m.
	/Medical Examiner	4a Facility Name (If not institu	tion, giva straet and nu	m <i>ber</i>)				4b. City, To	wn, or L	ocation of Deat		County of		0.10	Pezite
	Examine	FutureCare -	Chesapeak	2			1	Arnol	Ы		An	ne A	rund	el	
	Funeral	5. Social Security Number	6. Sex	7. Age (In yrs. last	t birthday)	If Undar		If Under	24 Hrs.	8. Date of Bir			9. Birthola	ca (State o	r Foreign
	Funeral Director	217-07-7772 Usual Residence of Decedent	1□ M 2XXF	84	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, De March	29,19	16 M	Counti laryl		
	w H	10a. State 10b. Cou	nty	10c. City, T	own or Lo	cation							10	d. Inside Cit	y Limits
	Sa-1 sh offind a		Arundel	Arno	ld									1 🗆 Yes	No No
	ifier deeth with the Mer r Itams 23s or 28s-1 si niner must be notified funeral Director	10e. Street and Number 305 College	Parkway			10f. Zip		1012			10g. Citiz	usa Usa	nat Countr	y?	
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land	Mai H d oth evan	17. Fathar's Name (First, Midd				18. Mother's Name (First, Middle, Malden Sumama) Alice Unknown									
Maryland	ges 1 and 2 should it of Heelth and Mer if item 27 is marke or other traumatic	19a. Informent's Neme/Relation Andrew Grubb								ral Route Numb					
altimore,		20a. Method of Disposition 1 Burial 2 Crematic 4 Donation 5 Other	sition (Nar malory or o st Ce			1	11/13 2000			ity or Tow					
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B	permit. Departminenta any inju	Hardesty Funeral Home, P.A.											ID 21		
	Physician /Medical Examiner purple used to the use of the used to	23. Part Enter the decame of complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (er as e consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Collagenous collisions of the conditions of the conditions of the collisions of the c										Approximate nterval Betwo	ween Death		
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	deet de att ed fo	Part II. Other significant cond	littions contributing to de	eath but not resultin	ng In the u	nderlying o	ause gi	ven in Part	l.	23b. Dld	tobacco u	use cont	ribute to	the cause o	of death?
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al Re		pulmor	ary di.	sease,	121	rail	ins	suffi	cier	,0	Yes 2	No	10	Yes 2□	No
5	Physician: this certific and director,	25. Was case referred to med examiner?	Hospital:				Ott	hor . /		th (Check only		Пон.	/O . W		
of	Physic this c ral dire	1 Yes 2 No 27. Manner of Death	28a. Date		VOutpatier 3b. Time of		DA	4) N	ursing H	ome 5 Res 28d. Describe					
L C	Ing I	1 Natural 5 □ Per	iding (Mon	th, Day Year)	Injury		8c. Inju Wo		INo	200. Describe	now injury	OCCUITO	4		
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_	To the Hospital within 24 hours a To the Funeral I completely filled Medical Ce	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and content on the basis of examination and/or investigation, in my opinion, deeth and manner stated.)	
	the uple	and manner stated. 29b. Signature and title of certifiar 29c. License number 29d. Date signed (Month, Day, Year)									lav Yearl				
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DHMH 16 Rev 6/95

Registrar

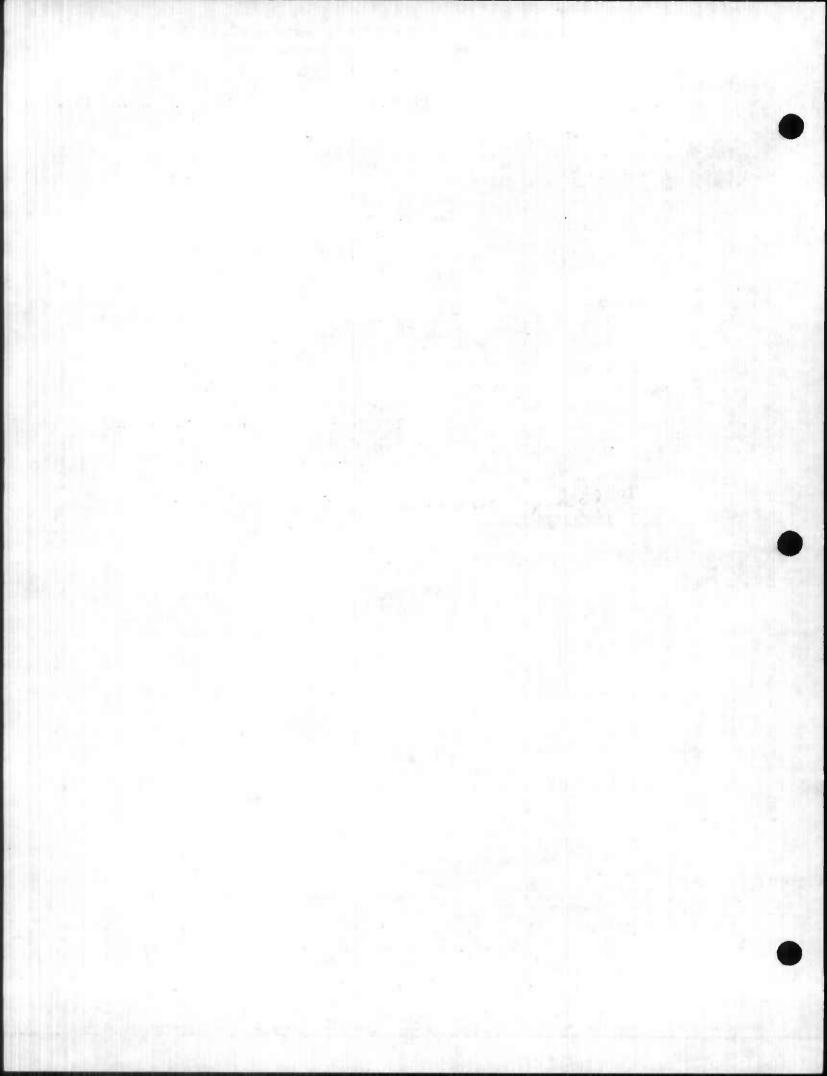


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State Registrar

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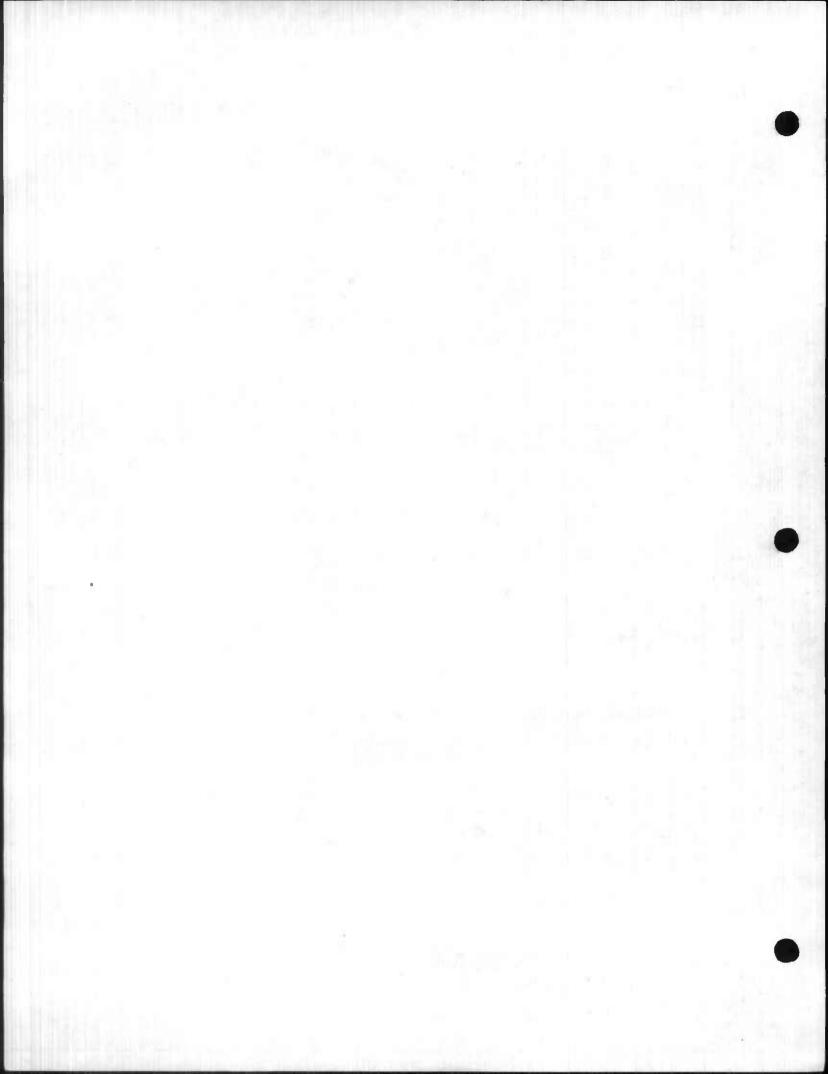


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

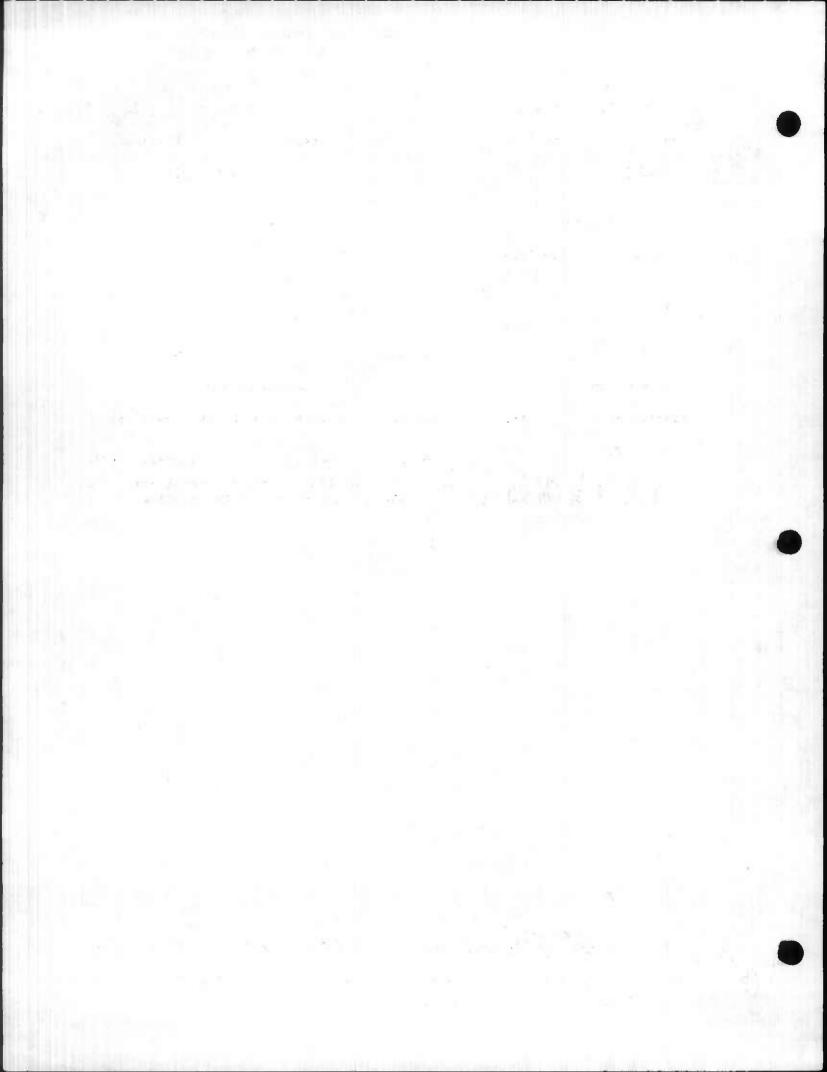
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			Certific	cate of	Death		R	eg. No.	U S	6329		
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Physician /Medical	Diane Tucker	Quattlebaum				1	Month,	774	2000	0850		
Examiner	4a Facility Nama (If not institution, give	re street and number)			4b. City, To	wn, or Loca	ation of Death	4c. County	of Death			
	Deaton Specialist	Hospital and H	lome		Balti	imore		N/A				
Funeral	5. Social Security Number 6. S	Sex 7. Age (In yrs. la	st birthday) If U	Inder 1 Year	If Under		B. Date of Birth	Vacel		lace (State or Foreign		
Director	249-19-0884	□ M 200 F 41	Yrs.	itris Days	nours	WIWI.	(Month, Day, 12/10/1	958	Count	Ċ'		
2	Usual Residence of Decedent											
show at an	10a. State 10b. County	10c. City,	Town or Location	1					10	Od. toside City Limits		
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th will	803 Irvington Str	eet		207	745			USA				
	11. Marital Status	12. Was Decedent Ever in U,S Armed Forces?	i. 13. Was D	Decedent of I	lispanic Ori	gin? (Spec	ity Yes or No- ican, etc.)		e - America			
and T		1 ☐ Yes 2 M No If Yes, Give		es 201 No		, , , , , , , , , , , , , , , , , , , ,	out, oto.,					
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TIES .	17. Father's Name (First, Middle, Last				18. Mothe	er's Name (First, Middle, I	Maiden Suman	10)			
should be ind Mentel marked o umartic evo	J. W. Reed				Whi	lemer	nia Tuc	ker				
ges 1 and 2 should be t of Health and Mentel if item 27 is merked or or other treumetic ev	19a. Informant's Name/Raletionship (Type, Print)	19b. Meiling Add	dress (Street	and Numbe	er or Rural	Routa Number	, City or Town,	State, Zip	Code)		
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	shock, or heart failure. List only	one cause on each line.	DO NOT SINES UNO	mode of dy	ng, soures	Cerdiac or	respiratory air	63 1,		Intarval Between Onset and Death		
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Examiner	disease or condition resulting in death)	a	epticem	110]					1	INC		
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has by pe 2 sh									of c	mpletion of cause death?		
The la							1 🗆 Y	es 2 No	10	Yas 2000		
startification.	25. Was case referred to medicat				26. Place	of Death	Check only or	10)				
Physicien: The this certificate rai director, peg	axaminer? 1 Yes 2 No	Hospitat 1 Inpatient 2 E	R/Outpatient 30	DOA OI	her: 4 Nu	ursing Hom	e 5 Reside	ence 6 Oth	er (Specify	()		
Printer in	27. Manner of Death		28b. Time of	28c. Inju Wo				ow injury occur				
Att. Att.	1 Staturat 5 Pending 2 Accident investigatio		Injury M		Yes 2	No						
tal or Attending P is effect deeth. In Director: After ted in by the funeral Certification:	3 Suicide 6 Could not b	28	f. Location (S	treet and Numi	per or Rura	I Route Number,						
Paris Pre	4 Homicide	detarmined 28e. Place of Injury - At home, larm, street, lectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural City or Town, State)										
at a series	29a, Certifier 1 Certifying Ph	vaician: To the best of my know	ledge, death occu	rred at the ti	me, date an	d place, an	d due to the c	ause(s) and m	anner as st	ated.		
To the Hospital or Attending Physibin 24 hours eter deeth. To the Funeral Director: After the completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one) 15' Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one) 16' Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one)											
Me the								9d. Date signe	d (Month, I	Day, Year)		
F 3 F 8	- Ne		Alfah	h 1	1049			11/2				
2								-1/	,			
182 5	30. Name and address of person who completed cause of death (Hom 23a) (Type, Print) **NES Alam Death Medical ONN 611 South charles St Boltmore M 121030									30		
14.	31. Date filed (Month, Day, Year)			JI 11 C-11	1-3	3/						
State		32. Registrar's Signatu	4 1									
Registrar	NOV 1 5 2000	Denina L	1. 100	a Kal								



State of Maryland / Department of Health and Mental Hygiene 0 0 36330

								Cer	tificat	e of	Death			Reg. No).		000	O	
Ohou	oloio		1. Decedent's Neme (First, I	Aiddle, Li	ast)						9 - 2		2. Dete of De Month			Yeer	3. Time o	f Death	
	sicia: edica	_	Mary T.	(Quinn				7 11 1				Novembe			2000	8:15	a.m	
	mine	_	4e. Fecility Neme (If not inst			umber)					4b. City, To	wn, or L	ocation of Deet			y of Deeth			
			Manor Care Nu	100000	-				-		Towso					more			
Fune Direct			5. Sociel Security Number 003-10-7263 Usuel Residence of Decade		9ex 1□ M 2XF	7. Age (In) 89	rs. last bii	Yrs.	# Under Months	Days		Min.	(Month, Da 07/08/	th IV. Year 191	1	9. Birthp Coun MA	lece (State of	or Foreign	
how			10e. Stete 10b. Co	unty		10c.	City, Tow	n or Loc	cation							11	0d. Inside C	ity Limits	
he Ma		Director		imor	re	C	atons	svil	_									2 No	
23e or 2	1	rai Dir	10e. Street end Number 715 Maiden (Choic	e Lane				10f. Zip	Code 1228	3					Whet Coun State			
filed within 72 hours efter death with the Maryland Hygiene. Hydiene. The maturel', or fleme 23e or 28e-f show mit, me man meters of the meter	, In .	by Funeral	11. Marital Stetus 1 Never Merried 2 3 Widowed 4 Divo		Armed F	2 No	n U,S.		Vas Deced Yes, spec			gin? (Sp n, Puerto	pecify Yes or No Pican, etc.)	-	Blee	ck, White, o	∍tc.		
72 hours "naturel",		erec			ducation ade completed)	16e	(Give I	ent's Usue kind of wo	rk done	during mos	t of worl	king	16b. Kind of Businass/Industry			lustry		
d within 72 hc jiene. r then "netur		Completed	Elamantary/Secondary (0-12	12)	Collage ((1-4or 5+)	$T\epsilon$	ille. D	<i>o not</i> us er	se retire	ed)	Educa			cati	On			
be filed tal Hyg d other		00	17. Fether's Neme (First, Mic	idie, Lasi	t)						18. Mother's Name (First, Middle, Maiden Sumeme)								
lid be fental ked o		0	George Quinn								Ther	esa	Carney						
C = N L	Kieron Quinn			tionship		(Son) 26 Sparks S											Code)		
0 - 7 5 5						Stete	camete	ry, crem	etory or o	ther pla	ace)	1	Deta 1/13/00			City or To			
permit. Pages Department of Important: if ite				Vice Lice	Jula	ck.	1			_		Sch	wab Fur	era	1 Ho	me, I	nc.		
Physicia	an		23a. Pert1. Enter the disaes shock, or heart failure.	e, or con List only	one cause on	caused the deach line.	In Do	not ente	r the mod	le of dy	ing, such es	cardiac	or respiretory e	rrest,			Approximst Interval Bet Onset end	tween	
/Medic Examin	er	Ĭ.	Immadiate Ceuse (Finel disease or condition resulting in death)		e. P	-	U/ c (or es e			A									
macuted n end el-transit	Fyaminer	-Vail III	Sequentially list conditions, if any, leading to Immediata causa. Enter Underlying Cause (Disease or Injury	ſ	b	Due to	o (or es e	consequ	uence of):										
Seeth certificate be executed settlending physician end of for use as the buriel-transit	100	-	causa. Enter Underlying Cause (Diseese or Injury that Initiated events resulting In deeth) Lest	1	с	Due to	(or es e	consequ	ence of):										
0 2 9	100	5			0											1			
	Physician	2	Pert II. Other significent cor	ditions	contributing to d	leath but not	resulting la	n the un	derlying c	ause gi	iven in Pert I		23b. Did	tobacco	use co	ntribute to	the cause	of death?	
s thet	hy Ph		STRU	K	E -	E	171	DH	Y5	E	MA	2	10	Yes 2	2□ No	3 Prob	ably 4	Unknow	
aw requii	pleted	2 -	2 -									12:		24e. Wes	en euto rmed?	psy	con	ra autopsy f lieble prior t npletion of c leeth?	to
The law ate has b	6	5											10	Yes 2	No	1	Yes 2	No	
Physician: The this certificate ral director, pag	B B		25. Wes case rafarred to me examiner?	dical							26. Place	of Deel	th (Check only o	ne)					
Physic this co	P	-	1 Yes 2 No				□ ER/Ou	Itpatient		A		rsing H	ome 5 Resi	denca	6 □Oth	ar (Specify)		
Jing After fune	atlon:							28c. Injury et Work? 28d. Describe how injury occurred											
To the Hospital or Attend within 24 hours efter deel To the Funeral Director: completely filled in by the	Certification:							City or Town, State)											
To the Hospital or within 24 hours eft To the Funeral Dir completely filled in	edicai											enner es ste end due to	eted. the causa(s	s)					
withir To th	Z		29b. Signeture end title of ce	Illian .		1.					se number			29d. Da	te signe	d (Month, L	Dey, Year)		
	ט		1	Nagma and address of parson who complated ceuse of daeth (Itam 23a) (Type, Print)															
UB"			30. Nama and address of par	son who	D1. M)	0. 7	600	Type, P	Print)	EI	e B	2. 1	TOWSO	w	, 1	Tel.	212	04	
	State			ear)	Garas 32.5	Registrer's St	neture	ha.	11										



State of Maryland / Department of Health and Mental Hygiene

				Certifica	te of	Death		Reg	, No. U U	36	331
Physician	1. Decedent's Neme (First, Middle, L Charles	Ritchie	161.31					te of Death	Day 2000	Year	Time of Death 5:25 pm
/Medical Examiner	4a Facility Name (If not institution, g 107 West Main Stre						n, or Location	-	4c. County		
Funeral Director		Sex 7. Age (i	n yrs. last birti	rs. If Und Month	er 1 Yeer Deys	If Under 2	Min. (Mc	e of Birth onth, Day, Y		9. Birthplace Country) 1916	(State or Foreig
f show	Usuel Residence of Decedent 10a. State 10b. County MD Ce	cil	Oc. City, Town	or Location	rylan	đ		18	34 7		Inside City Limit
ufer death with the Meryland frame 23a or 28a-f show frame 23a or 28a-f show frame Director	10e. Street and Number 107 West Main Street			10f. 2	ip Code 219	11		10g		What Country?	
urs after Hi, or he by Fui	11. Merital Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Even Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes:	er in U,S. Unk.	If Yes, sp	edent of lecify Cub	an, Mexican,	in? (Specify Ye Puerto Rican,	es or No- etc.)		e - American I ck, White, etc.	
nation and a second	15. Decedent's (Specify only highest g	rade completed) College (1-4or 5+)	16a.	Decedent's Us (Give kind of v life. DO NOT	vork done	during most (d)	of working	16	Aistono	usiness/Indust	ry
BEF O	12 17. Father's Name (First, Middle, Later Convert Control Ritchia)		R	Au	Jales	_	's Neme (First,			10)	
nd 2 should be faith end Mental bith end Mental be 27 ls marked or freumatic every freumatic e	19a. Informant's Neme/Reletionship Anna Ritchie / Wife						or Rural Route				de)
permit. Pages 1 and 2 Department of Health of Important: If frem 27 is eny Injury or other tra price.	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special Control of Contro	Removal from State	cemeter	Disposition (A y, cremetory o	other ple	oce) Novem	ber 14, 2			city or Town, are City,	
permit. Departri	21. Signature of Funeral Service Lic	ensee Victor P.	Doda, Jr	Charle	s L.		Funeral nue, Balt		Inc. Maryla	and 21	230
Physician /Medical	23a. Part1. Enter the disease, or co shock, or heert feilure. List on Immediete Cause (Final disease or condition		e death. Do n	ot enter the m	ode of dy	ing, such as c	ardiac or respi	ratory arres	t,	Ap Int	pproximate lerval Between nset and Deeth
Examiner	resulting in deeth)	a		onsequenca o	f):					1	
triticate be executed g physician and es the bunal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Du	e to (or as a c	onsequenca o	f):	W					
	resulting in death) Last	Du	e to (or es e c	onsequence o):						
5 55 %	Part II. Other significant conditions	contributing to death but r	not resulting in	the underlying	cause g	iven in Pert I.	2				e cause of dea
		The Part of the Pa				100					ly 4 Nnkni
aw requires been 2 should								la. Wes en performe	autopsy ed?	evailal	eutopsy finding ble prior to letion of cause ath?
ysicien: The I s certificate ha director, page To Be Corn	25. Was case referred to medical					26. Place	of Deeth (Che	1 🗆 Yes		1 🗆 Y	es 2/2 No
Physicien: this certific ral director. To Be	exeminer? 1 Yes 25 No	Hospital: 1 Inpatient			DUA		sing Home 5				13-11-15
After fune	27. Menner of Deeth 1 Natural 5 Pending 2 Accident investigate 3 Suicide 6 Could not determine	be 28e. Piace of Injury	- At home, fer	njury M		Yes 2 N	lo 28f. Lo	cation (Stre		ber of Rural R	oute Number,
	4 Homicide building, efc. (Specify) 29a. Certifier (Check only one)										
To the H within 24 To the Fi complete	29b. Signature and title of certifier	A Sun	Als ,		9c. Licer	se number	and at the	290	d. Date signe	er 12,	y, Year)
Do	30. Name and address of person who Thomas A. Bio				Av	e. Ha	vre de	Gra	ce MI	210	78
State	31. Pale (iled 1 Magith 200 Year)	Bene32 Registrar's		bouts	1	•					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Marvland / Department of Health and Mental Hygiene 0 36332

					Ce	rtificat	e of	Death		F	Reg. No.		
Di .		1. Decedent's Nema (First, Midd	die, Last)							2. Dete of Dee		Yaar	3. Tima of Death
Physici Medic		Florence			Ro	У				Novembe		2000	5:15 PM
Examir		4e. Facility Name (If not Institution	on, give street end num	ber)				4b. City, To	wn, or L	ocation of Deeth	4c. Count	y of Deeth	
		College Manor,	Inc.					Luthe	ervi	lle	Balt	imore	
Funeral Director		5. Social Security Number 215-42-1079	6. Sex 7 1 □ M 2 □ F	7. Age (In yrs. les 91	st birthday) Yrs.	If Under Months	1 Yaar Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Dey July 8	/, Yeer)		olece (Stete or Foreign otry) nsylvania
show		Usual Rasidence of Decedent 10a. Stata 10b. County	у	10c. City,	Town or Lo	ocation						1	0d. Inside City Limit
with the Maryland a or 28a-f show Le notified at	ctor	Md. Balt	imore	Bal	ltimo	re							1 ☐ Yes 2 ☑ N
23a or 2	Funeral Director	10e. Street and Number 7826 Chelse	ea St.			10f. Zip	Code	212	204		10g. Citizen of	What Cour USA	itry?
ter des	by	11. Marital Status 1 Never Married 2 Ma. 3 Widowed 4 Divorce	rried 1 Tes 2	2 ⊠ No		Was Decedif Yas, specif Yas				pecify Yas or No- Rican, etc.)	14. Rai Bla Specil	ce - Amaric ck, White, by:	
72 hours "netural",	eted	15. Decede (Specify only highe	nt's Education est grada complated)		(Give	dent's Usue	rk done	during mos	at of work	ing	16b. Kind of B		
2 . 5	Completed	Elementery/Secondery (0-12)	College (1-4	4or 5+) +3	Homemaker						Own Ho	2m c	
should be filed within nd Mental Hygiena. marked other than umatic event, the Mental Mental Control of the Men	Be Co	17. Father's Neme (First, Middle		73	Homemaker			18. Moth	er's Nem	e (First, Middle,			
uld by Menta rked rice	To B	Martin Sent	man					E	lizal	oeth Co	nard		
1 and 2 should be file Health and Mental Hy em 27 Is marked other other traumatic event		19a. Informent's Name/Reletion Mollie R. Bucy				ng Address 6 Che				ral Route Numbe			Code)
permit. Peges 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If Item 27 Is marked other that any Injury or other traumatic event, the longe.		20e. Method of Disposition 1 Buriel 2 Cremetion 4 Donetien 5 Other (3	Specify)	tate	Ltop	osition (Nametory or o Servi	ce (Co.		Dete 1-14-00	20c. Location		
Physician /Medicai Examiner	iner	23e. Pert. Enter the disease, of shock, or heart feilure. Lis Immediate Causa (Finel disease or condition resulting in death)		TRO	KE								Interval Between Onset and Deeth
an and	Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	S 0.	Due to (or e	s a conse	quence of):							
eeth certificete be executed attending physician and for use as the burial-transit	Medical	thet initieted events rasulting in deeth) Last	c	Due to (or es	s e consec	quance of):							
deeth c	clan												
that the deeth cert ed by the attandin detached for use	Physician	Pert II. Other significant conditi	Fboil	th but not rasulting	ng In the u	inderlying c	ause gh	ven in Pert I	1.	23b. Dld to			the cause of death bably 4 🗆 Unknow
requiras been sign should be	Completed by	Congestir	e Hear	+ Fo	าก	we				24e. Wes a	an autopsy med?	av	ere sutopsy findings eliable prior to mpletion of causa death?
The law ate hes page 2	Com	Ostepart	hritis							1 U Y	es 2 No		Yes 2□ No
iclan: The certificate rector, pag	Be	25. Wes case referred to medica axaminer?	ıl					26. Plece	of Deet	th (Check only or	ne)		
Physician: this certific ral director,	To	1 Yes 2 No	Hospitel: 1 ☐ Inp	patient 2 EF	VOutpatier	nt 3 DC	A Oth	ier: 4 Nu	ursing Ho	ome 5 Resid	ence 6 🗆 Ott	ner (Specify	y)
D 20 0		E C Problogit	igetion	Injury 28 Day Year)	Bb. Time o Injury	f 2	8c. Injui Wor 1 🗆			Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred			
al or Atte s after de il Directo ed in by t	Certification:	3 Suicide 6 Could 4 Homicide detam	nined 289. Plece of	f Injury - At home g, etc. (Specify)	e, farm, str	reet, fectory	, office			28f. Location (S City or Tow		ber or Rura	l Route Number,
To the Hospital or Attendit within 24 hours after death. To the Funeral Director: All completely filled in by the fu	edicai (29e. Cartifiar (Check only one) 1 Certifyii 2 Medical	ng Physician: To the be Examinar: On the best end manne	is of examination	edge, deeti n and/or in	n occurred ovestigetion,	et the tir	me, date an opinion, dee	d piece, oth occur	and dua to the cred at the time, d	ause(s) and m lete end plece,	annar as st and due to	ated. tha cause(s)
14	Me	29b. Signeture and title of certific	J. M.	Com		M) 290	Licens	e number	2	129	29d. Data signe	od (Month,	Dey, Year)
& a		30. Name end eddrass of person	who completed cause			Print)	Mis	ita	Ba	16 mas	4 2	121	0
Sta	te	NOV 1 5 2000	32. Reg	gistrer's Signetur				1					

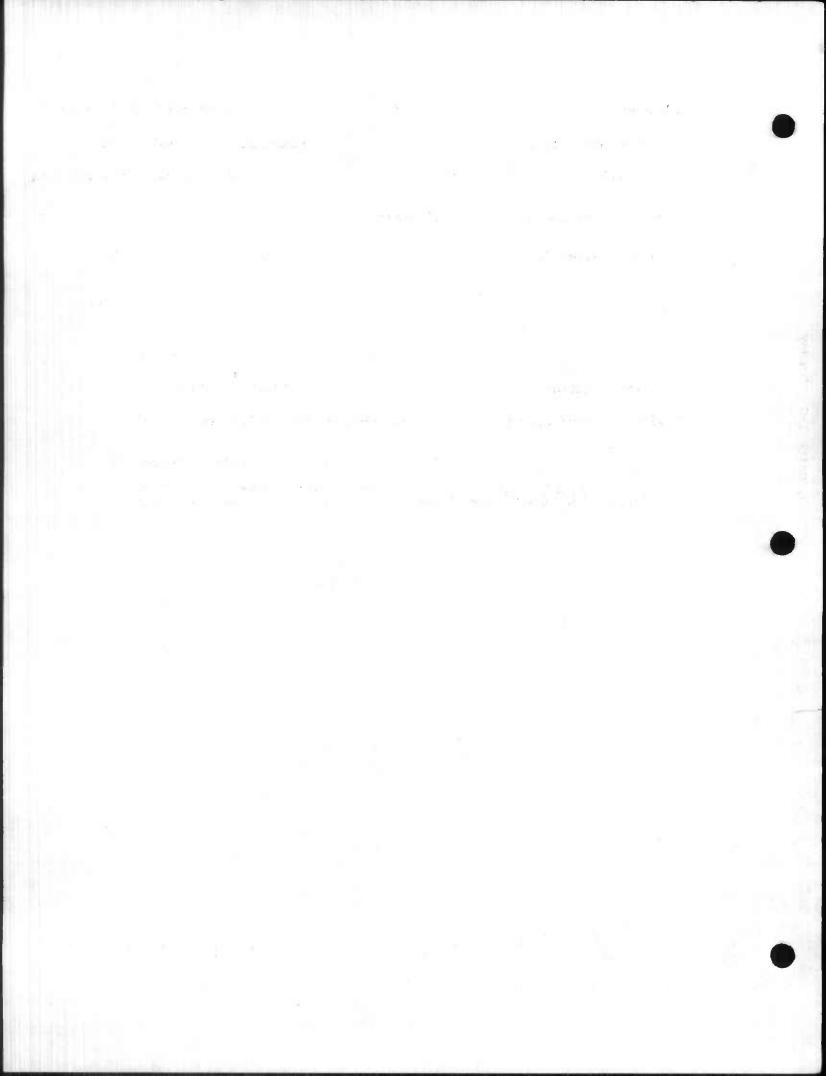
Registrar

Monday

W. University Pkwy. Suite 1-G

500

Dr. William McConnell



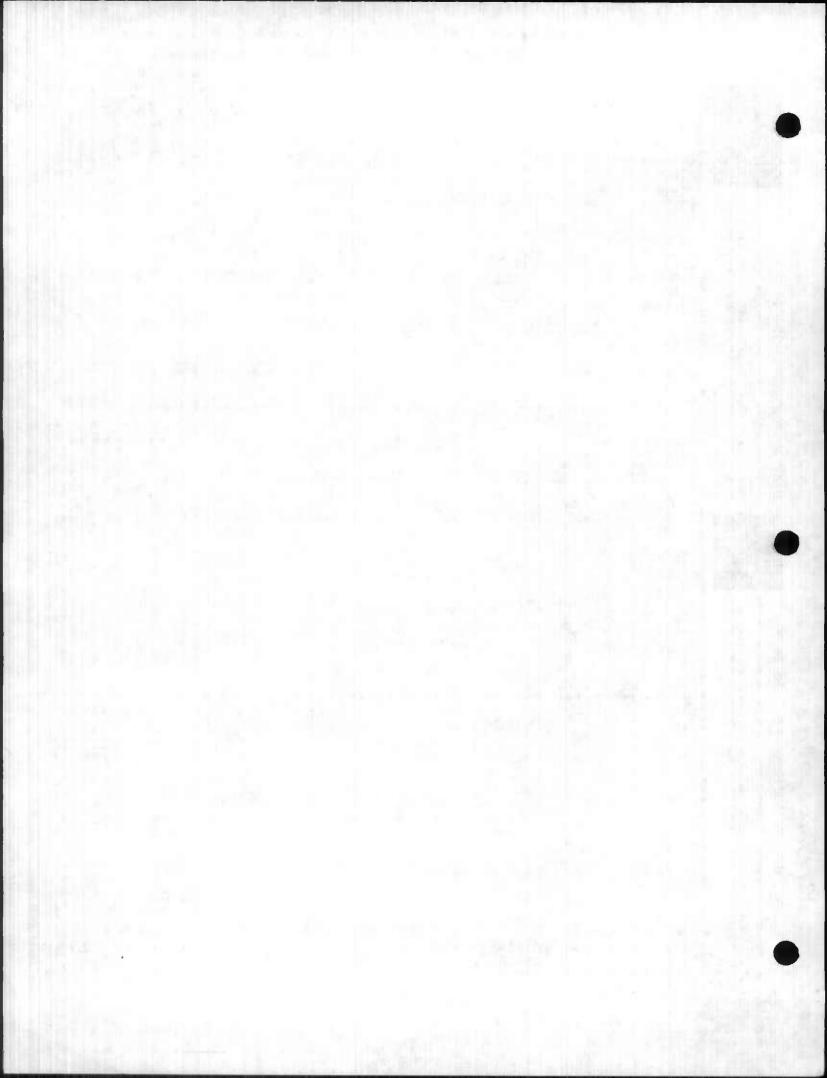
	State of Maryland / Department of Health : Certificate of Death		giene	36333
Physician /Medical	KDDECCH KICE	2. Date of De Month	eth	Year (: 30 PM
Examiner	4e Facility Neme (If not institution, give street and number) FRANKFORD AT LORIEN NURSING CENTER 4b. City, To	own, or Location of Death	4c. County of N/A	
Funeral Director	220-14-2597 10 M 20 F 85 Yrs. Months Days Hours	r 24 Hrs. 8. Date of Bir (Month, Da DEC • 2	y. Year) 1,1914	9. Birthplace (State or Foreign Country) SOUTHCAROLIN
23s or 25s-f show ant be notified at	Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code		10g. Citizen of Wh	10d. fnside City Limits 1
e 23e or mat be		rigin? (Specify Ves or No	U.S.A.	- American Indian,
ours after death v rait, or items 23s Examiner must	3 ☐ Wildowed 4 ☐ Divorced Year or Detes:		Black,	White, etc. AMERICAN
led within 72 ho tygiene. Are then "neturn A, the Medical.]	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Only the property of the propert	st of working	16b. Kind of Bus	iness/Industry
uld be filed Mental Hygid rhad other dic event, II	17. Father's Neme (First, Middle, Last) 18. Moth	ner's Name (First, Middle, CARRIE HO	Maiden Surneme	
and 2 sho eaith and A h 27 is ma her traums	19a. Informant's Name/Reletionship (Type, Print) ROOSEVELT RICE(brother) 19b. Meiling Address (Street and Number 3906 FERNDALE As 20a. Method of Disposition (Neme of 20b. Placa of 20b. Plac		IMORE, M	
Physician /Medical Examiner Popularium P	21. Signature of Funeral Service Licenses 22. Name and Address of Facility 22. Name and Address of Facility 22. Name and Address of Facility 23. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Finel disease or condition resulting in death) Due to (or as a consequenca of):	CRUGGS FUN	ERAL HO ALTO, M	ME
yaicis yaicis he bur	Cause (Disease or injury that initiated events Due to (or as e consequence of):			
es that the death certifica igned by the attending ph be detached for use as it by Physician/Med		1	tobacco uee cont Yea 2□ No	tribute to the cause of death? 3 Probably 4 Unknown
The law requires cate has been sig , page 2 should b			an autopsy ormed?	24b. Were autopsy findings available prior to completion of cause of death?
enticate his solor, page	25. Was case referred to medical 26. Plac	1 ☐ ce of Death (Check only	Yes 2 000	1 ☐ Yes 2 De No
Physical this certain draw	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 No.	Nursing Home 5 Resi	denca 6 Othe	r (Specify)
			how injury occurre	d
tal or Attending P in after Geath. at Director: After ted led in by the funan- Cartification:	3 ☐ Suicide 4 ☐ Homlcide 6 ☐ Could not be determined 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify)		Street and Numbe wn, State)	r or Rural Route Number,
n 24 houp n 24 hou he Funer pletsly fill	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date e 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, de and manner stated.			
of the same	29b. Signature and title of certifier Walther & Thousand tempor 7457.	57	MOV	(Month, Day, Year) 10, 2000
VV	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MATTHEW MCNABNEY 5505 (HOPKINS B 31. Date filed (Month, Dey, Year) 32. Registrar's Signeture	My wes c	1 Role	BALFMA
State	31. Date filed (Month, Dey, Year) 32. Registrar's Signeture			

DHMH 16 Rev 6/95

Registrar

NOV 1 5 2000

Resecu Rice



State of Maryland / Department of Health and Mentai Hygiene

Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** Edna Arlene Swinyard Nov. 11, 2000 21:25 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, give street and number) Examiner Sandy Spring, MD Sharon Nursing Home Montgomery 8. Dete of Birth (Month, Day, Year, If Under 1 Yeer If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 114-34-3785 1 M NOF 78 Yrs. 17, NY May Director Usuel Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f ahow MD Montgomery Sandy Spring 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "netural", or items 23a or addical Examples (18201 Slade School Road 20860 United States Pages 1 and 2 should be filed within 72 hours after deeth vinent of Health and Mahrall Hygiene.

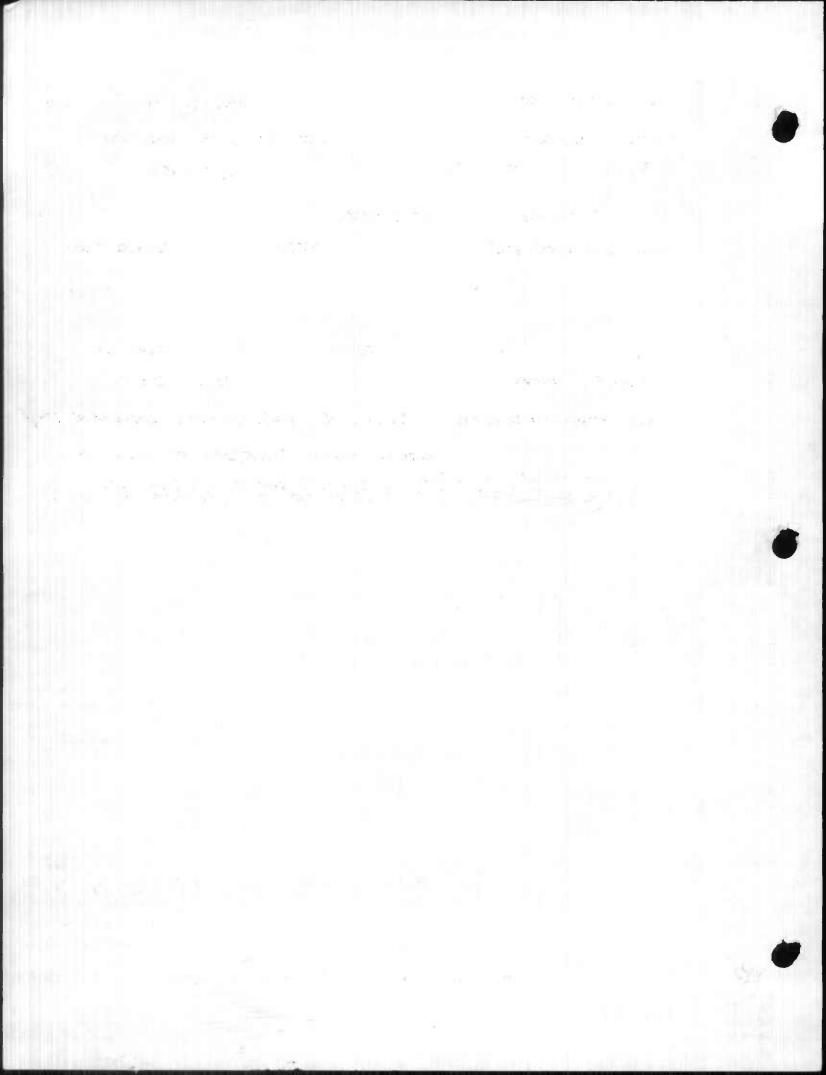
ment of Health and Mahrall Hygiene.

mit: If Item 27 is marked other than "natural", or Itema 23, ury or other traumatic event, in Mourtain Exertion mail. Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 14. Race - American Indien Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Never Merried 2 Merried White Baltimore, Maryland 21215-0020 1 Yes 25 No Specify: Specify. p 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 4 Teacher Education 12 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be Frederick Grube1 Lillian Traxe1 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. tnforment's Name/Reletionship (Type, Print) Nancy Swinyard / Daughter 5225 Pooks Hill Road, Apt 428 N Bethesda MD 20814 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State important: If the any injury or oth 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Kinderhook Cemeetry NOV. 15, 2000 Kinderhook, NY 22. Name end Address of Facility
Charles L. Stevens Funeral Home, Inc.
1501 East Fort Avenue, Baltimore MD 21 Signature of Funeral Service Licensee Victor P. Doda 21230 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete tntervel Between Onset and Deeth Physician Immediate Ceuse (Final disease or condition resulting In death) /Medical Pneumonia Examiner Examiner tracture physician and the burial-transit The law requires that the death certificate be axecuted Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Last Due to (or es a consequenca of): P.O. Box 68760, 19 Physician/Medical 50 disease 980 0 signed by the a d be detached f 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, à 24b. Were eutopsy findings aveilabla prior to completion of cause of deeth? been sic 24e. Was an eutopsy performed? Completed page 2 s has 2 2 No 1 Yes 1 ☐ Yes certificata director, Attanding Physician: Be 25. Was case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 8 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28c. Injury et Work? 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred opp injury 1 Neturel 5 Pending death. 5:50 p. M. 1 TYes couch thin 24 hours after death.

the Funeral Director: Ampletaly filled in by the fu 24,2000 investigetion 2 Accident 6 Could not be 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Nursing Home 28f. Location (Street and Number or Rural Route Number, City or Town, State) | \$30 | 5 | \alpha de School Rd., Sandy Spring MD 3 Suicide 4 \(\text{Homicide} \) ŏ 29a. Certifier edical 2 Medical Examtner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete and placa, and due to the cause(s) end menner stated. (Check only one) within 2 \$ 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture and title of certifier 200 30 Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Pike, PMB 348, Rockville, MD 20852 lom9 Ko atricia 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State NOV 1 5 2000

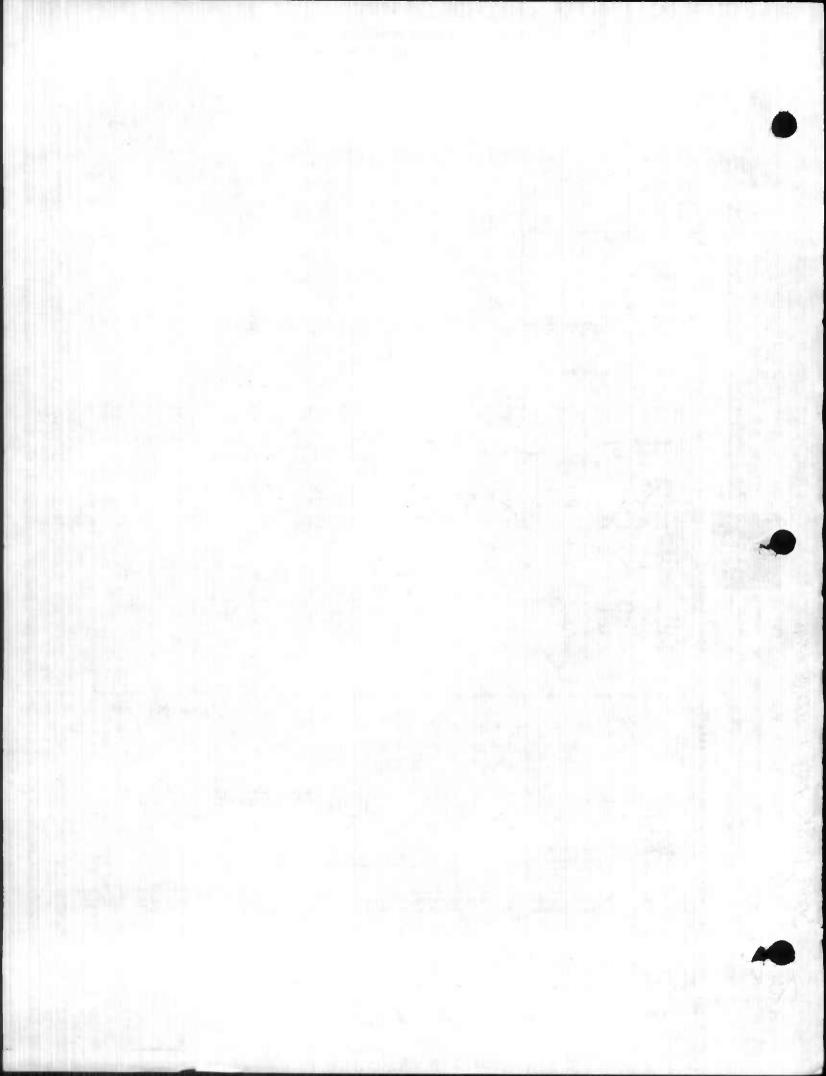
Registrar **DHMH 16 Rev 6/95**



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Deta of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Deuk Y. Song 3:40 pm 11, 2000 Nov. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Deeth Examiner Bethesda Montgomery Suburban Hospital If Under 1 Year | If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) 8. Data of Birth (Month, Dev. Year) **Funeral** Deys 1₩ 2□ F 534-72-4245 80 Yrs. Director Dec. 3, 1919 South Korea Usual Residence of Dacedent 10a. Stata 10c. City, Town or Location 10d. Inside City Limits 10b. County 23a or 28a-f ahow the Medical Examiner must be notified at MD Montgomery Boyds XX Yes 2 No Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 21930 Greenbrook Drive Boyds USA Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☒ No If Yes, Give Yaer or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Reca - American Indian, Black, Whita, etc. natural, or items 11. Maritel Status hours after 1 Never Married & Married Baltimore, Maryland 21215-0020 Asian 1 ☐ Yes 2 No Specify: P 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working tifle. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Korean Government Mechanical Engineer 12 other 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) 1 and 2 should be fill lealth and Mental H m 27 is marked off Se K. Kim Nam S. Song 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) permit. Peges 1 and 2 sh Department of Health and Important: If Hem 27 is m eny injury or other traum Soon Hee Tam / Daughter 4236 West Tumble Creek Drive, Franklin WI 53152 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State Highland Memorial Park, November 15, 2000 New BerlinWI 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee Victor P. Toda, Jr. 22. Name and Addrass of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland Approximate tnterval Between Onset end Deeth 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician tmmediate Cause (Finel disease or condition resulting in death) */Medical STEPSIS Examiner Due to (or es a consequence of): 41 Crawassix Sequentially list conditions, if eny, teading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequenca of): HUPOXIT Song, Duek Nov. 11, 2000 @ 340g Dua to (or as a consequenca of): Physician/M been signed by the a should be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes by 24b. Ware autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? Completed page 2 s 25. Was case referred to medical axeminer? 26. Plece of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1) Inpatient 2 ER/Outpatient 3 DOA edical Certification: To After this 28c. Injury at Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending Investigation Injury 1 ☐ Yes 2 ☐ No death. 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year) 29b. Signature and title of cart 29c. Licansa number 451280. November 11, 2000 30. Nama end address of person who completed cause of death (Item 23a) (Type, Print) Dadgar Anushiravan, MD 13219 Executive Park Terr., Germantown Maryland 20874 31. Date filled (Month, Dey, Year)
NOV 1 5 2000 32. Registrar's Signature State Registrar

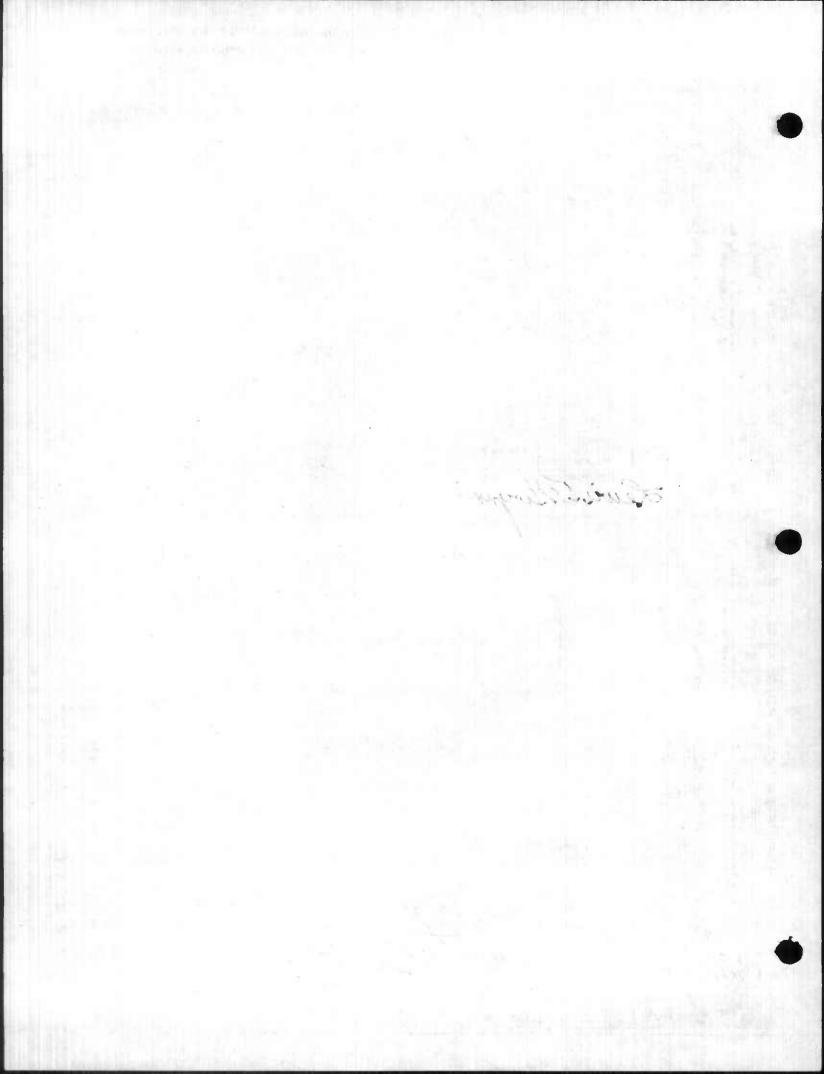


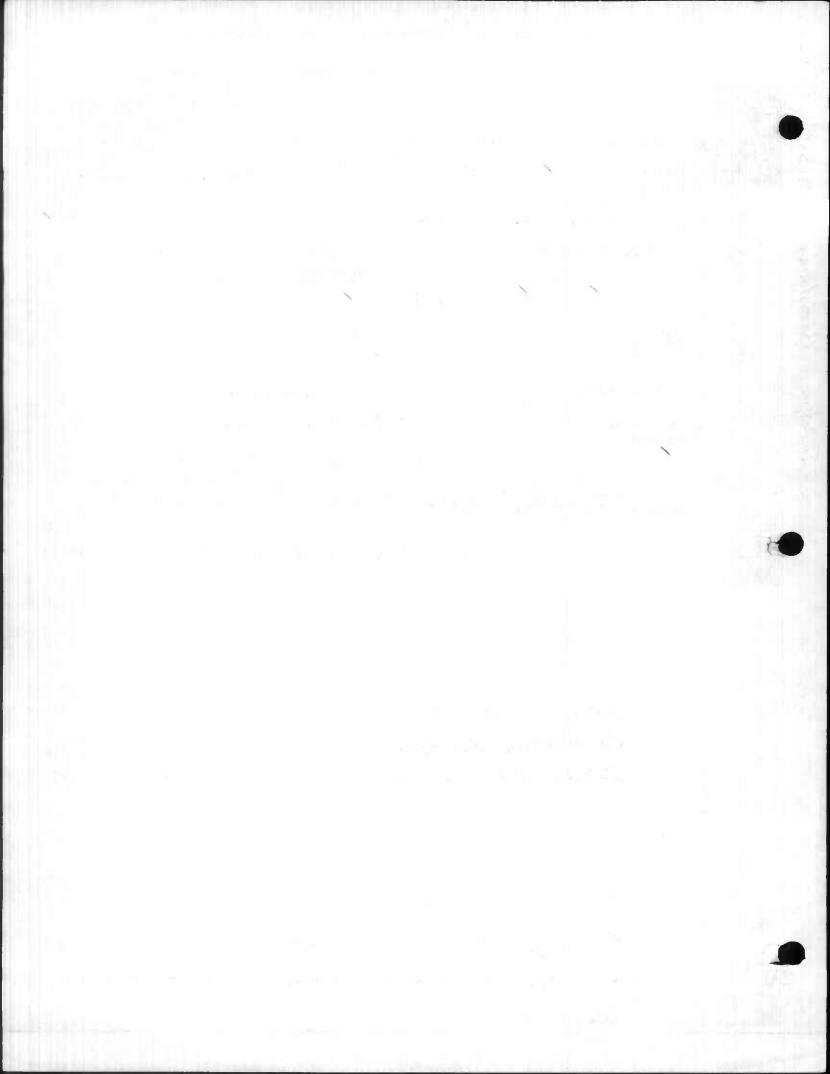
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tims of Death Year Month 33 **Physician** overtoer 4c. County of Death NUR /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) Examiner Baltimone Mary land Universit If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Days M 2DF Months Hours 219-22-9466 Director JULY 9,1929 MARYLAND Usual Residence of Decedent the Maryland r 28a-f ahow 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits Yes 2 No Director N/A BALTIMORE MD. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code should be filed within 72 hours after death with and Mentel Hygiena.
In rarked other than Instural; or flems 23a or it unrarde others. U.S.A. 962 N.FRANKLINTOWN RD. 21229 Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 27 Yes 2 □ No if Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Merried 2 □ Married 1 Yes 2 No Specify: Specify: BLACK P 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) STATE OF College (1-4or 5+) Elementary/Secondary (0-12) 3 years 12th SOCIAL WORKER MARYLAND permit. Pages 1 and 2 should be fits Department of Health and Mental Hy Important: If Item 27 Is marked oths any injury or other traumatic avent, DDCs. 18. Mother's Name (First, Middle, Meiden Surname) 17. Father's Name (First, Middle, Last) WALTER STOKES MARY HARRISON 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) SHARON M. CROSBY-NEICE 4808 WILERN AVE.BALTO.MD.21215 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 2 ☐ Cremation 3 ☐ Removel from State 4 □ Donation 5 □ Other (Specify) GARRISON FOREST VET. 11/16/00 OWINGS MILLS.MD. 21. Signature of Funeral Service Licensee LEWIS . GWYNN²². Name and Address of Facility LEWIS T.GWYNN FUNERAL HOME PARKHEIGHTS AVE. BALTO.MD. 21215-6393 Leveper 4517 23a. Pert1. Enter the diseese, or complication shock, or heert failure. List only one cars. Approximate Interval Between Onset end Death that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical hzing Examiner Due to (or as a consequence of): Examiner overwhe certificate be executed g physician and as the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as e consequença of): attending p The law requires that the death signed by the a 23b. Did tobacco uss contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? should I Completed 24a. Wes an autopsy After this certificate has funeral director, page 2 1 Yes 2 0 No 1 Yas or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 10 Menner of Death 28b. Time of 28c. 28d. Describe how injury occurred Certification: Injury at Work? Injury 5 Pending 1 Natural death. 1 Yes 2 No investigetion 2 Accident Director: / 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 T Homicide within 24 hours a To the Funeral D completaly filled Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

| Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, dete and placa, and due to the cause(s) and manner stated. edicai 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cartifing rell ted cause of death (Item 23e) (Type, Print) Baltimone, MD 2120 South Greene ho 31. Date filed (Month, Day, Year) 32. Registrar's Signature 5 2000 NOV Registrar

DHMH 16 Rev 6/95

parker ORIGINAL





State of Maryland / Department of Health and Mental Hygiene

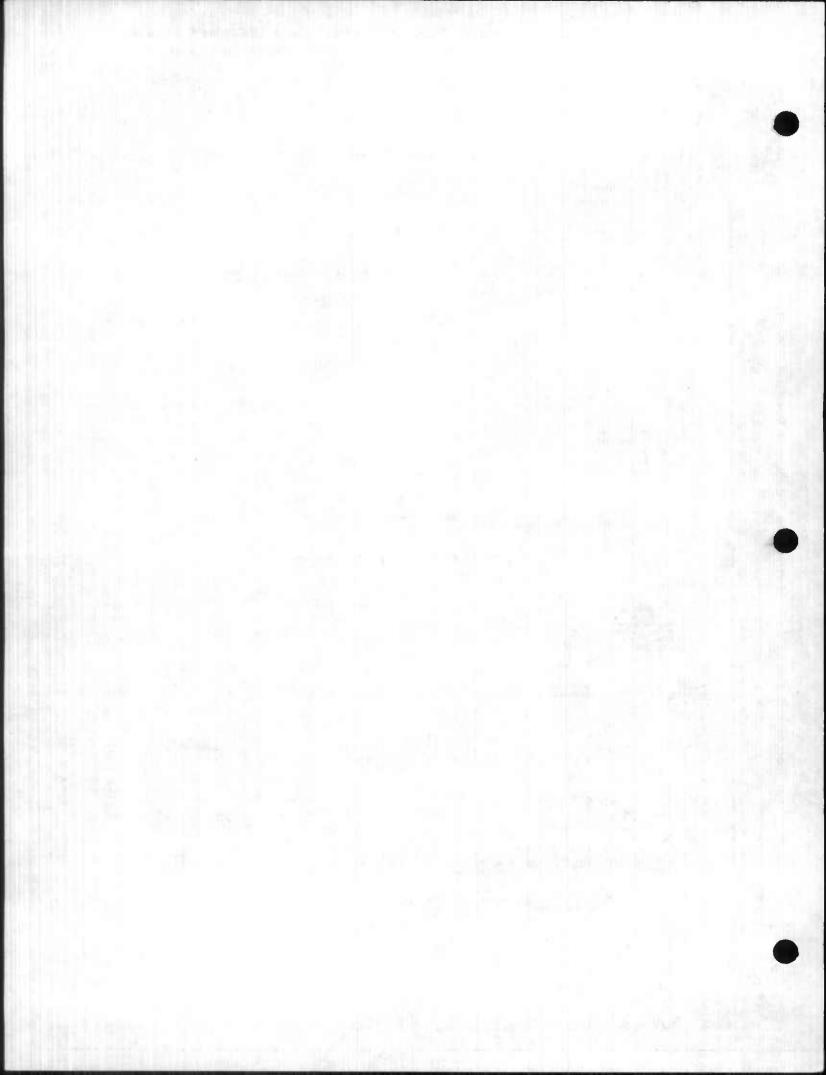
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 12:50 a.m. Christopher B. Schwerdt November 12 2000 /Medical 4a Fscility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5 Trembly Court Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) **Funeral** Months 10 M 20 F Days Hours Yrs. 54 California 564-64-9480 07/31/1946 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or items 23e or 28e-f show the Medical Exerciner must be notified at 1 Yes 2 No Directo MD Baltimore Catonsville 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 21228 5 Trembly Court United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Merital Stetus Pages 1 and 2 should be fired within 72 hours after nent of Health and Mental Hygiene. ant if them 27 is marked other than "natural", or Ms Yes 2 1000 f Yes, Give Year or Dates: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1□ Yes 2√No Specify: White Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Electrical Engineer Northrop Grumman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Carlton E. Schwerdt Patricia Ruth 19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: if them 27 is any injury or other trax ans. Sally R. Schwerdt 5 Trembly Court, Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremetion 3 Removal from State 11/15/00 Baltimore, Maryland Loudon Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Sterling-Ashton-Schwab Funeral Home, Inc. 21. Signature of Funeral Service Licenses 736 Edmondson Avenue, Catonsville, MD 21228 ie, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory arrest, List only one cause on each line. 23a. Part 1 Enter the disk Approximate Interval Between Onset and Death **Physician** 2 zyers /Medical Immediate Cause (Final disease or condition resulting in death) TRIGNOMA Examiner Due to (or as a consequence of): Physician/Medical Examiner Tha law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Due to (or es e consequence of) ate has been signed by the a page 2 should be detached Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, Be Completed by 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 1 ☐ Yes 2 No this certificate or Attending Physician: 25. Was case referred to medical axaminer? director. 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending investigation 1 Naturai efter death. 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours of To the Funeral C Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the tima, date and place, and due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely To the 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 038409 11/13/20 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) BALTIANE, 21093 SMMFMW Rd 711F# 10753 FAUL 6146111 31. Date tiled (Month, Dey, Year) 32. Registrar's Signature

DHMH 16 Rev 6/95

Registrar

NOV 1 5 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND#19A PER F.H. G789 11-15-2000 JAB Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day H Month Year **Physician** SAAKB SEREBRYANYY NOVEMBER 12, 2000 /Medical 4a Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE H Under 1 Year H Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) APR • 15 1930 7. Age (In yrs. last birthday) 70 Yrs. 5. Social Security Number 9. Birthplaca (State or Foreign **Funeral** XXM 2DF UKRAINE Yrs. 214-41-4005 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE RANDALLSTOWN 1 ☐ Yes 2 No Directo 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 3503 BEAGLE LANE APT. 103 21133 USA Berns 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 Married "natural", or I Baitimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE ğ 3℃ Widowed 4 Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within 72 ho ment of Health and Mental Hygiene. ant it fleen 27 is marked other than "naturary or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) OFFICER MILITARY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BARUCH SEREBRYANYY BASYA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MRS. IRENA KOCAN/DAUGHTER 64 JONES VALLEY CIRCLE BALTIMORE, MD. 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If any Injury or Otice. 5 Other (Specify) BALTIMORE HEBREW 11/13/00 REISTERSTOWN, MD. 4 Donation 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208 23a. Part1. Enter the disease, or shock, or heart failure. List only that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, asse on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finat disease or condition resulting in death) /Medical · METASTATIC RENAL CELL CARGNOMA Examiner Due to (or as a consequence of): Examiner EF MEPHRELTOM sician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the buria Box 68760. Physician/Medical Due to (or as a consequence of) attending p P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown PLEURAL EFFUSION signed t Records. by cate has been sig 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed HYPERCALCEMIA 1 Yes 20 No 1 Yes 2 No Division of Vital Attending Physician: 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: 1 Stanpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 2√ No this funeral 27. Manner of Death 26a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Naturat 2 Accident 5 Pending investigation Ne Hospital or Attending in 24 hours after death.

The Funeral Director: After bletch filled in by the fun 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) To the To the To the I

State Registrar

32. Registrar's Signature MORTHWEST HISPITAL 31. Date filed (Month, Day, Year) NOV 1 5 2000

multi mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINDER P MEHTA BANDALLSTOWN oaks

29c. License number

D0041410

29d. Date signed (Month, Day, Year)

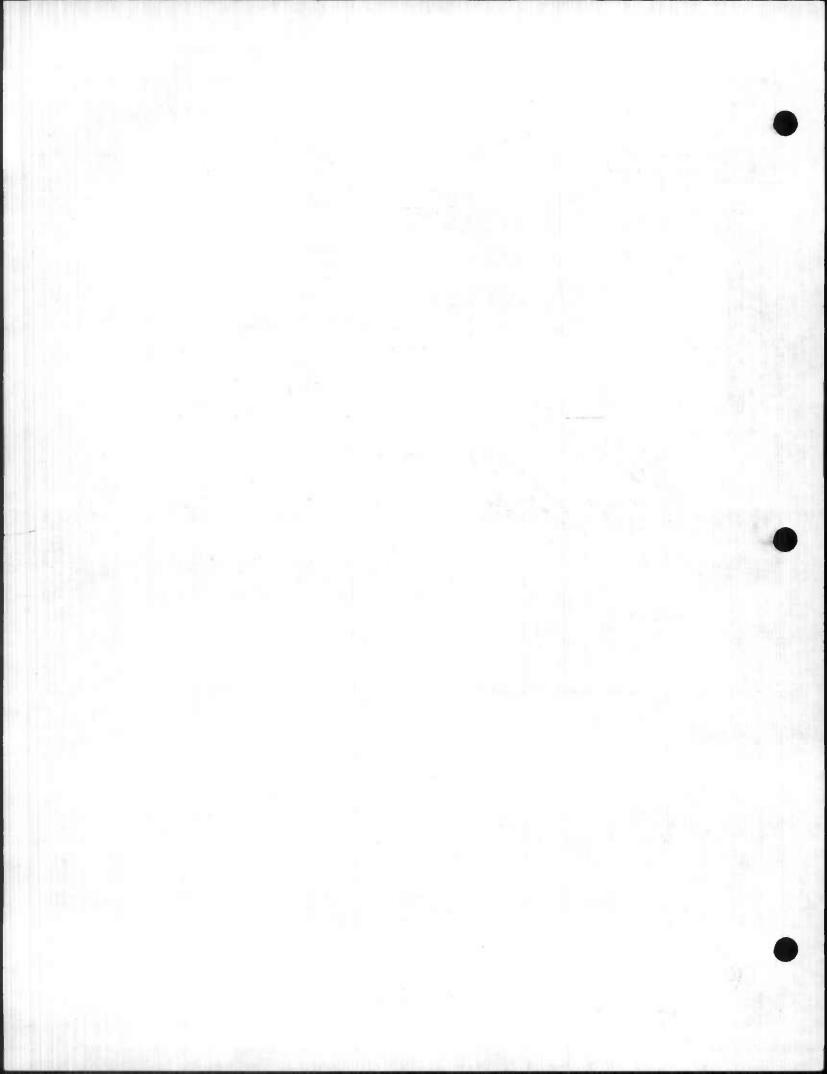
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DHMH 16 Rev 6/95

29b. Signature and title of certifier

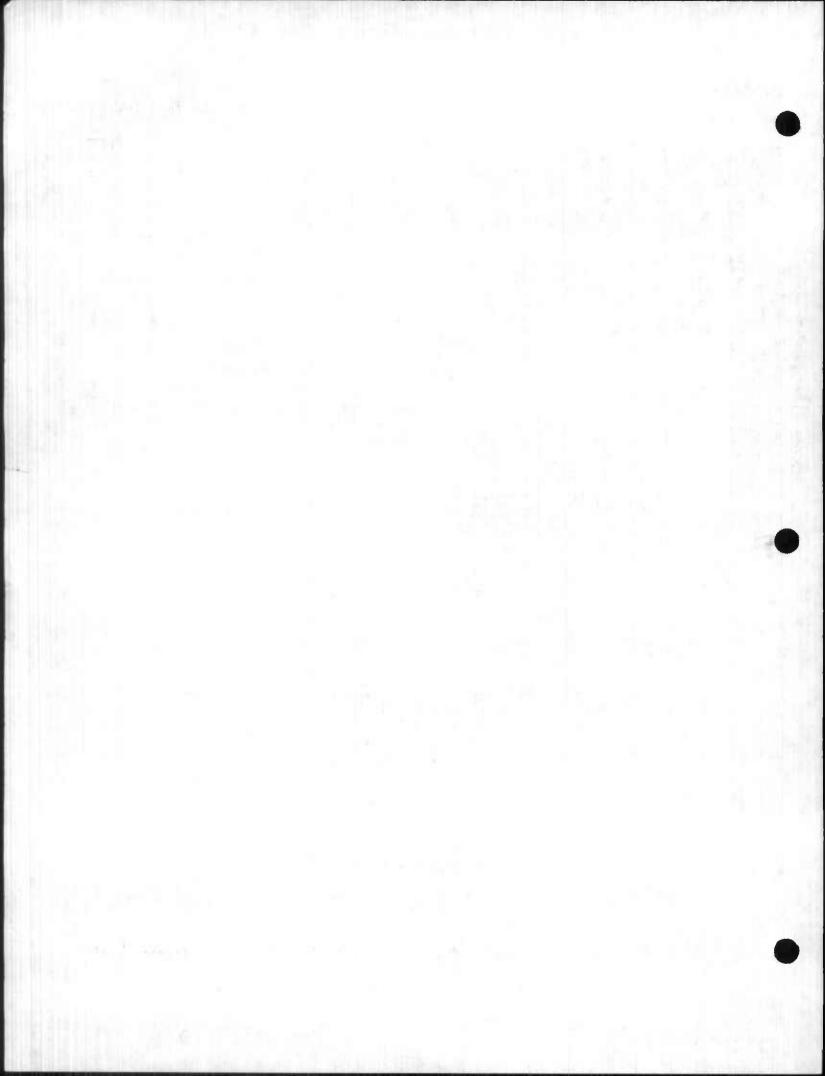
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State of Maryland / Department of Health and Mental Hygiene 10 36310

					Cei	rtificate o	f Death		Reg. No.	0		10
	1. Decedeni's Name	(First, Middle,	Last)					2. Date of De Month	ath Day	Year	3. Tima of	Death
Physician /Medical	Renee	J	Thompso	n-Cole	2			November		2000	9:4	apm
Examiner	4a Facility Name (#					1 3 4		Location of Death	4c. County	of Death		
	Sinai	Hospi	tal of	Baltin	NOE-6		Baltimo	ne Cita		N	A	
neral	5. Social Security No		3. Sex		. last birthday)	If Under 1 Ye	ar If Under 24 Hrs	8. Dale of Birt	th Venel	9. Birthr	place (Stete	or Foreig
tor	220-78-2	2192	1□ M 2□F	38	Yrs.	Months Day	ys Hours Mill	05-02	-62	Cour	MD	
	Usual Residence of											
Examiner must be notified at by Funeral Director	10a. State	10b. County			ity, Town or Lo					1	IOd. Inside C	
cto	MD	N	A	Ва	altimo	re					1 ☑ Yes	2UN
Director	10e. Street and Num	ber			1916	10f. Zip Cod	0		10g. Citizen of	What Cour	ntry?	
3 2	4613 Ho	rizon	Circle	Apt.	#103	212	08		USA			
Funeral	11. Marital Status		12. Was Dec	edent Ever in U	U,S. 13.	Was Decedent	of Hispenic Origin? (Juban, Mexican, Pue	Specify Yes or No	- 14. Rac	ca - Americ	can Indian,	
5	1 Never Marrie	d 2 Marrie		2₽ No		1 ☐ Yes 2K☐ N		ito thousand orday	Specif		010.	
by	3 Widowed	4 Divorced	Year or D		A. 1/20	10 100 201	to specify.		Specii	Bl	ack	
Completed	(Speci	15. Decedent's	Education grade completed)		16a. Deced	dent's Usual Oc	cupation ne during most of wo ired)	orkina	16b. Kind of B	usiness/în	dustry	
ple	Elementery/Secon		College (1-4or 5+)	life.	DO NOT use ret	ired)	Jirany				
No.	12th Gra	de	NA		Admi	n. Ass	istant		Morga	n St	ate [Ini
Be	17. Father's Name (First, Middle, La	ast)				18. Mother's Na	ame (First, Middle,	Maiden Sumer	ne)		
To	William	n	Thomps	on			Alice		Bro	wn		
	19a. Informant's Ne	me/Relationshi	p (Type, Print)		19b. Mailin	ng Address (Str	eet and Number or F	Rural Route Numb	er, City or Town	, State, Zip	Code)	
	Alice	В. 5	Thompso	n	1208	Morre	ene Road	d Durha	m, NC	277	05	
te de	20a. Method of Disp	osition		20b.	Piace of Dispo	sition (Name of	n/a cel	Date	20c. Location	- City or To	own, State	
7 0	1X Burial 2 ☐ 4 ☐ Donetion		Removal from	State		m. Pk.		1-16-20	00 Ran	dall	stown	. M
any injury or other traumatic avent, the Medical Exertions. To Be Completed by F	21. Signature of Fur			/				-				
any one	· (n	. 14	(1			rch FH	altimor				.02
	Ole Peril Fried	NIN								Ave	Approxima	le.
	shock, or heer	t teilure. List of	nly one ceuse on e	eech line.	am. Do not em	er the mode of	dying, such as cardia	ac or respiratory e	11636		interval Be	tween
cian lical	Immediate Cause (F	Finel	,		1					- 1		
ner	disease or condition resulting in death)	1	a	-iven f	Tailme							
-				1 1 1	(or as a consec	quence of):				1		
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ial-transit Examiner	Sequentially list con	ditions,	Agriculture.	Due to	(or es e consec	quence of):						
s the burial-transit edical Examir	Sequentially list con if any, leading to im- cause. Enter Under Cause (Disease or I	tying njury	C							i		
edical	thal initieted events resulting in death) L.			Due Io (or es a conseq	uence of):				i		
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for use a		A 25 M										
etached for us Physician/	Part II. Other signific	cant condition	s contributing to d	eath but not re	sulting in the u	nderlying cause	given in Part I.	23b. Did	tobacco uss co	ontribute t	o the causs	of dea
Phy	Penul	Fil						10	Y88 2 No	3 Pro	bably 4	Unkn
b b		Tailw	re					-				
								24a. Was	an autopsy med?	81	ere autopsy ailable prior	to
. page 2 should										of	ompletion of death?	cause
lirector, page 2 s o Be Compl								10	Yes 200No	1	□Yes 2Å	No
Be C	25. Was case referr	ed to medical					26. Place of Do	eath (Check only	one)		V	1
	examiner?	No	Hospital:	Inpatient 20	☐ ER/Outpatie	nt 3 DOA	Other:	Home 5□ Resi		her (Speci	(v)	
- F	27. Manner of Death			of Injury oth, Day Year)	28b. Time o		njury at Work?		how injury occu		.,,	
ed in by the tuner Certification;	1 Natural 2 Accident	5 Pending investigs		ith, Day Year)	Injury		Work? I□Yes 2□No					
y Pe	3 Suicide	6 Could no	l ha	of Injury - At I	home, farm, st	reet, factory, offi	Ce	28f. Location (Street and Num	ber or Rur	al Route Nur	nber,
-	4 Homicide	Gotomini	build	ing, etc. (Spec	eity)	reet, factory, offi		City or To	wn, State)			
	29e, Certifier	1M Cartifulna	Physician: To the	haet of my ko	owledge deat	h occurred at the	e time, date end plac	ce, and due to the	causa(s) and m	Annar as	hateta	
edical			caminer: On the b				y opinion, deeth oc					s)
Me	29b. Signature and I	title of certifier	1			29c. Lic	ense number		29d. Date sign	ed (Month,	Dey, Year)	
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V	H.C	maly	nom	-, r	(11)		() -000		Novembe	~ 11	1000	
1	30. Name and addre	ss of person w	ho completed caus	se of deeth (Ite		11	100	D 11.				
	H. Chris	topher	Lawson	1	Sin	ai Hospi	tal 8t	Baltimo	او			
State	31. Date filed (Monti	h, Day, Year)	32. F	Registrar's Sign	nature							
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N.				State of Maryla		tificate of			g. No.	36341
	Physician	1. Decedent's Nam	na (First, Middla, Last)				2. Date of Deat Month	Day .	3. Time of Death
l I	/Medical	Louise		Terry				NOVEMB	1	2000
	Examiner	1000	If not Institution, giva			100	4b. City, Town, or I Baltimo		4c. County	
! —		Union 5. Social Security I	Memoria Number 6. Sa	1 Hospital	rs. last birthday)	If Undar 1 Year				9 Birtholaca (State or Foreign
и	Funeral Director	247-20-		M X 83	Yrs.	Months Days	Hours Min.	8. Data of Birth (Month, Day,		Birthplaca (Stata or Foreign Country) SC
	D .	Usual Rasidence of	10b. County	100	City, Town or Loc	ation				10d. Inside City Limits
	with the Maryland a or 28a-f show the notting at	MD	NA							1 ☐ Yas 2 ☐ No
	the M 28s-f notifie	10e. Street and Nu			Baltimo	10f. Zip Coda		11	Og. Citizen of V	22.21
	ifer death with the Ma r ferme 23e or 28e-fe sites ment be mother Funeral Director			Lake Driv	.802	212	17		USA	
	Rema 23	11. Maritat Status		12. Was Decedent Evar In Armed Forcas?	U.S. 13. W	as Decedant of I	Hispanic Origin? (Span, Maxicen, Puart	pecify Yas or No-	14. Race	e - Amarican Indian, ck, Whita, etc.
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5-0	ed within 72 hours ygiene. or then "netural," f. tre Medical Ex.	(Spe	15. Decedent's Edu	cetion a complated)	(Give k	ent's Usual Occu	during most of wor	king	16b. Kind of Bu	usinass/Industry
2121	within then.	Elementary/Sec	ondery (0-12)	College (1-4or 5+)	lifa. D	O NOT usa retira	(d)		D 6	
	other other	8th Gra	(First, Middla, Last)	NA	Press	ing La		ne (First, Middle, A		ct Garments
Maryland	Mental H Mental H arked out artic ever	Lonnie	e Bru	20			Estell	T, e	enkins	
ary	2 should be man in man		lame/Relationship (T)		19b. Mailing	Addrass (Stree	t and Number or Ru			
	127 P	John	M. Bru		_		view Ro			Maryland
Baltimore,	0 = 5	20a. Mathod of Dis	sposition Cramation 3 P		. Place of Dispos cematary, cremi	ition (Nama of atory or other pla	ica)	Data	20c. Location -	City or Town, Stata
Him	poemit. Pag Department: Moortant: it any injury o	4 Donation	5 ☐ Other (Specify) unaral Sarvice Licens			Mem.	ace of Engility			Arbutus, MD
Ва	pemit. P Departme Importan any injur pace	Mere	a Che Co	ento	W	M.C.Ma	rch FH	1101 E.	North	ryland 21202 Avenue
		23a./Part1. Entar shock, or had	tha disaase or compl art failure. List only or	ications that dauged tha dena ceusa on each lina.	ath. Do not anta	r tha mode of dy	ing, such as cerdiad	or respiratory arra	ast,	Approximate Interval Batween Onsat and Death
	Physician /Medical	fmmediata Causa	(Final	(0.1050	0	1.1.				1 month
	Examiner	diseasa or condition resulting in death)	on	Severe 1	o (or as a consagu			3000		1 111011111
_	in it	1 Y Y Y Y		Cerebro		cular	ownt			1 month
	n and latranait	Sequentially list co	onditions,		(or as a consequ		200 01 11			
60,	racian se bundi	Sequentially list or if any, leading to in ceuse. Entar Und Cause (Disease or	erlying r injury	Cardia	c Agr	hyth	ma			3 weeks
68760,	office the	that initiated event rasulting in death)	3	Due to	(or as a consequ	ence of:				
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	d sate of for	Part ff Other signi	ficant conditions cor	ntributing to death but not r	esulting in the uni	derlying cause gi	ivan in Part I	23b. Did to	bacco usa co	ntributs to the cause of death?
, P.O.	that the death cert ed by the attending detached for use a y Physician/M							1 🗆 Y	25 No	3 Probably 4 Unknown
cords	The law requires that are has been agne, page 2 should be d				6500			24a. Wes a perform	n autopsy ned?	24b. Were autopsy findings available prior to completion of ceusa of death?
Re	The last page 2 Comp							1 🗆 Ya	s 20No	1 Yas 25 No
ital	5 to 5	25. Was casa rafa	rred to medicel				26. Place of Dec	eth (Check only on	7	
>	nyalch Na cer I dinec	axaminar?	(No	lospital: Desinpatiant 2	☐ ER/Outpatient	3□ DOA OI	ther: 4 Nursing H	loma 5 ☐ Raside	ence 6 🗆 Oth	er (Specify)
0		27. Mannar of Dea	th 5 Pending	28a. Data of Injury (Month, Day Year)	28b. Time of injury	28c. Inju		28d. Describe ho	ow injury occur	red
Division of Vital Records,	to a familiary or a familiary or a familiary of the famil	2 Accident 3 Suicide 4 Homicide	Invastigation 6 Could not be datermined	28a. Plece of Injury - Albuilding, atc. (Spe	t home, farm, stra		Yes 2 No	28f. Location (Si City or Town		ber or Rural Routa Number,
_	Funer funer listy fill	29a. Certifier (Check only		sician: To the best of my k						
	Med Med	one) 29b. Signature and	fille of certifier .	and menner steted.		29c. Lican	sa number	2	9d. Data signa	d (Month, Day, Year)
1	10	No.	ndin!	North		ATT	138946	A10 1	NOVEMI	BER 11,2000
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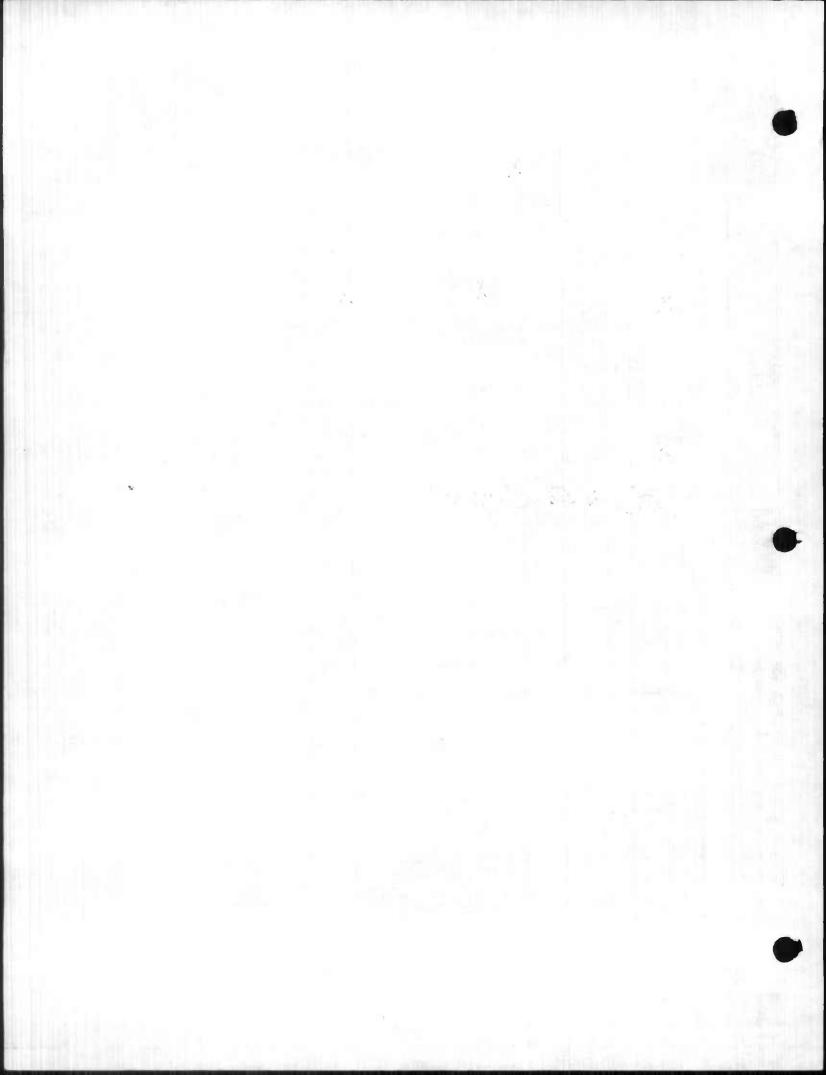
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36342 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Dev Month Physician NOVEMBER 14,2000 GERTRUDE JULIA 12:35AM TAYLOR /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner NURSING HOME CATONSVILLE FREDERICK VILLA BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2 F 219-92-7277 Usual Residence of Decede Director MARCH 1.1919 VIRGINIA the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location ahow rithen "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Yes 2 No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? ARBUTUS AVE. U.S.A. 21215 5123 death 12. Wes Decedent Ever in U,S. Armed Forces?
1 Yes 2 0 No If Yes, Give 7 Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 72 hours after 1 Never Married 2 Married 21215-0020 natural, or 1 Yes 2 No Specify: Specify 2 3 X Widowed 4 □ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) .. Pages 1 and 2 should be filled w trmant of Haalth and Mental Hyglen tant: If Item 27 is marked other th jury or other traumatic avant, the HOME MAKER DOMESTIC unknown unknown Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOHN HENRY MILTON ELMIRA NELSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MARY YERBY-ERVING-DAUGHTER 5123 ARBUTUS AVD.BALTO.MD.21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removel from State HEATHSVILLE permit. Page Department of important: If any injury or page. 4 □ Donation 5 □ Other (Specify) BAPTIST CHURCH CEM.11/18/00 VIRGINIA 22. Name and Address of Fecility 21. Signature of Furniral Service Licens LEWIS T.GWYNN FUNERAL HOME PARKHEIGHTS AVE BALTO.MD.21215-6393 23a. Pert 1. Einst the disease, or complications that pulsed the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervei Between Onset and Death Physician Immediate Cause (Finet disease or condition resulting in death) /Medical Atheroscleratic Cardiovascular Examine Due to (or es a consequence of) Examiner physician and the burier-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the causa of death? P.O. 1 Yas 2 No 3 Probably 4 Unknown Senile Dementia algned b Records. à 24b. Were autopsy findings aveileble prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 Yas 2 No 1 ☐ Yes Division of Vital Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2N No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending i or Attending after death. I Director: Aft d in by the fun 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital or within 24 hours aft To the Funeral Dicomplataly filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as atated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of pertifier D32158 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N. Eutaw St, Suite 407, Baltimore, MD 21201 Tyoten Parikh MB 31. Date filed (Month, Day, Year) 32. Registrar'a Signature State

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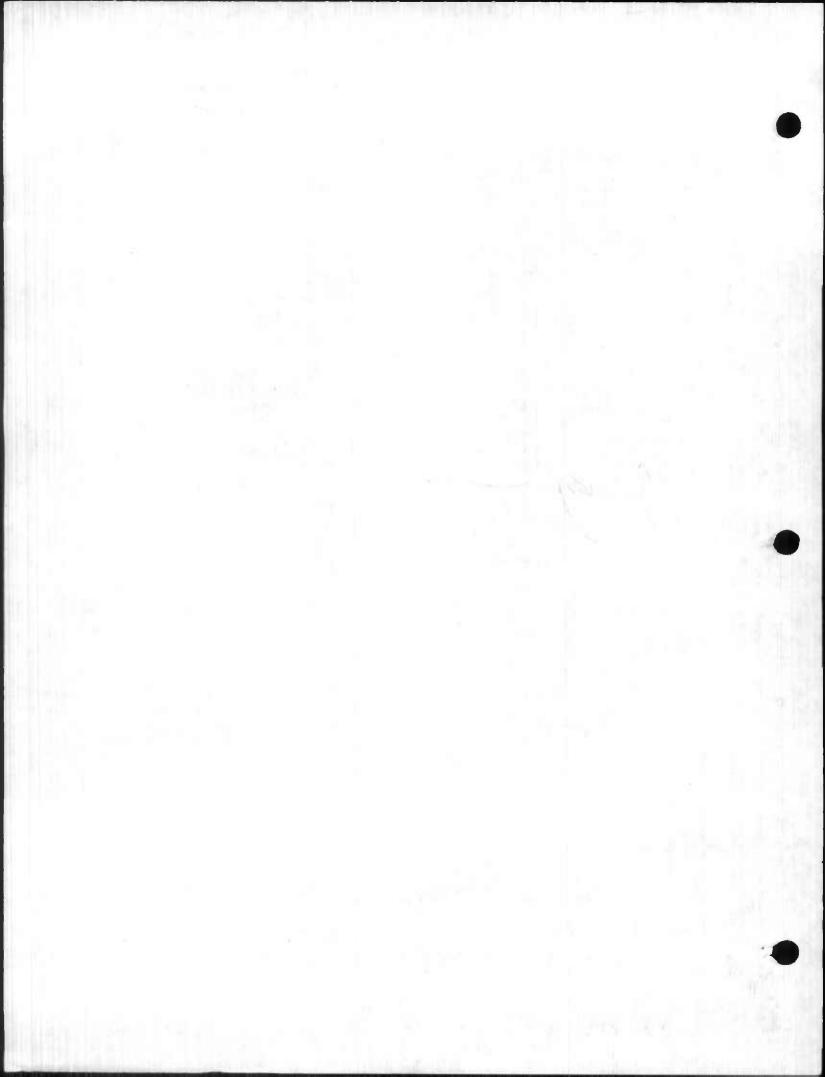
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State of Maryland / Department of Health and Mental Hygiene

Tubb					Cer	tificati	e of	Death			Reg. No.	UU	363	143	
_	. Decedent's Name	(First, Middle, Las						2. Date of De Month	eath Dey	Yea		na of Death			
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	John Hans						- 1		apol:			e An			
or	Social Security Nur 214-44-02 Isual Rasidenca of D	219	7. A	ge (In yrs. last	Vrs.	If Under Months	Deys	If Under 2 Hours	Min.	8. Date of Bir (Month, De Aug. 6	v. Year)	9. E Wa		ton, DC	
-		Ob. County		10c. City, T	own or Lo	cation					10d. Inside City Limits				
tor	MD	Anne Aru	undel	Arno	old						1 ☐ Yes XX				
ō	0e. Street and Numb		Court			10f. Zip		21012			10g. Citizen of What Country? USA				
by Fur	1. Merital Stetus 1 Nevar Merried 3 Widowed 4		12. Was Deceden Armed Forces 1XXVes 2 tr 1Yas, Give Year or Dates:	?] No				dispanic Origan, Maxican Specify:	gin? (Spe n, Puerto l	ocity Yes or No Rican, etc.)		Race - Ar Black, W	merican India Thite, etc. Whit		
Completed		5. Decedent's Edi only highest grad lary (0-12)		5+)	6a. Deced (Give lifa. L		al Occup rk done se retire	pation during most d)	t of workir	ng		d of Business/Industry			
	7. Father's Name (Fi	irst, Middle, Last)		T.	reciia	IIIC		18. Mothe	r's Name	(First, Middle	1		LVE		
o Be	Edward A.							100		la Selk					
-	19a. Informant's Nam Sharon Mi					-		and Numbe	er or Rura	Arno	er, City or 7				
2			Removal from State	9		sition (Name		ca) 1 Gard		Date 1/14 2000			or Town, Sta		
	1. Signature of Fune				22	Hard	lest	_	eral	Home,		MIT	21401	F. 1	
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ope	Cause (Disaasa or Injury that initiated events resulting in death) Last Due to (or as a consequence of):														
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Phys	art II. Other signification	ant conditions co	ntributing to death	but not resultir	ng in the ur	nderlying o	ause gi	van in Part I			Ysa 2			4 Unknown	
Completed by										24a. Wa: peri	s an autops; ormed?	y 24	ib. Were auto available p completio of daath?		
E O										1,20	Yes 2	No	1 🗷 Yes	2 No	
	5. Was case raferre	d to medical						26. Placa	a of Death	(Check only	one)				
To	examiner? 1X Yes 2 N	0	Hospital: 1 Inpat	tient 2 ER	/Outpetien	nt 3□ DC	DA Ot	her: 4 🗆 Nu		me 5 Res					
	7. Mannar of Death	5 Pending	28a. Date of In (Month, D	jury ay Year) 28	b. Time of Injury	2		ork?		28d. Describe				t was motor	
Certification:	2 Accident 3 Suicida 4 Homicide	2000 anjury - At home				Yes 2		281. Location City or To	(Street and own, State)	Number of Reute	r Rural Royte	Number Blue			
	29a. Certifiar 1 (Check only 2 one)	☐ Certifying Phy ☐XMedicat Exam	reletan: To the bes liner: On the basis and manner s	of axamination	dga, daath	occurred vestigation	at tha ti	ima, date an opinion, daa	d place,	and dua to the ed at the time	causa(s) s , data and p	nd manne	r as stated.	Marylanco	
	29b. Signature and till	te of certifier	Ma	ole,	, M.	0 29		se number C.M.E.	•				lonth, Day, Yo		
	O. Name and address	n 5, 1	Zaden:	12,	11		ın S	treet	, Bal	ltimore	e, Mar	yland	1 2120	1	
State 3	11. Date filed (Month,	Day, Year)	32. Regis	trar's Signature	An An	ak	1								



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36344 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 11th Year **Physician** MATTHEW E TUCKER 7:15 pm NOVEMBER 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GOOD SAMARITAN HOSPITAL BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days 1₩ 2□ F Hours 226-28-9535 77 Yrs. Director JULY 17,1923 VIRGINIA Usual Residence of Decedent 10a. State 10 MARYLAND 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE 1 □ Yes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 5537 WHITWOOD ROAD 21206 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Amed Forces:

\[Yes 2 \sum \no \10/2/43_1 \subseteq yes 2 \sum \no \Specify: Year or Dates: \12/13/45 1 Never Merried 2 Married AFRO-AMERICAN altimore, Maryland 21215-0020 3€ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) STEEL WORKER BETHLEHEM STEEL 7TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle Maiden Surname) . Pages 1 and 2 should be in ment of Health and Mental H tant: If Item 27 is marked off jury or other traumatic even MATTHEW TUCKER NATTIE DRUMMOND 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CARL TUCKER (son) 5537 WHITWOOD ROAD BALTIMORE, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State competery, crematory or other place)

NOV.17,2000

DULANEY VALLEY MEM.GARDEN BALTO. CO, 1 Burial 2 □ Cremetion 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility CALVIN B. SCRUGGS FUNERAL HOME 1412 F. PRESTON STREET BALTO, MD. 21213 death. Do not enter the mode of dying, such as cardiac or respiretory arrest, Approximate Intervel Between Onset end Death **Physician** /Medical Immediata Cause (Final 15 DAY disease or condition resulting in death) Examiner ASPIRATION PNEMONIA Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably ₩ Unknown MEART FAILURE, SEIZURES 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? HYPER TENSION 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical axaminer? 8 26. Plece of Deeth (Check only one) Hospital: 1 Suffipationt 2 □ ER/Outpationt 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Ather Division Netural 5 Pending after death. 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ò 24 hours a Funaral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and menner as stated.

2 ■ Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the Food 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 LOUI RAVEN BOVLEVARD, GOOD SAMARITANI MUSPITAL NGUYEN BALTIMORE, ELIZABETH 31. Date filed (Month, Day, Year)

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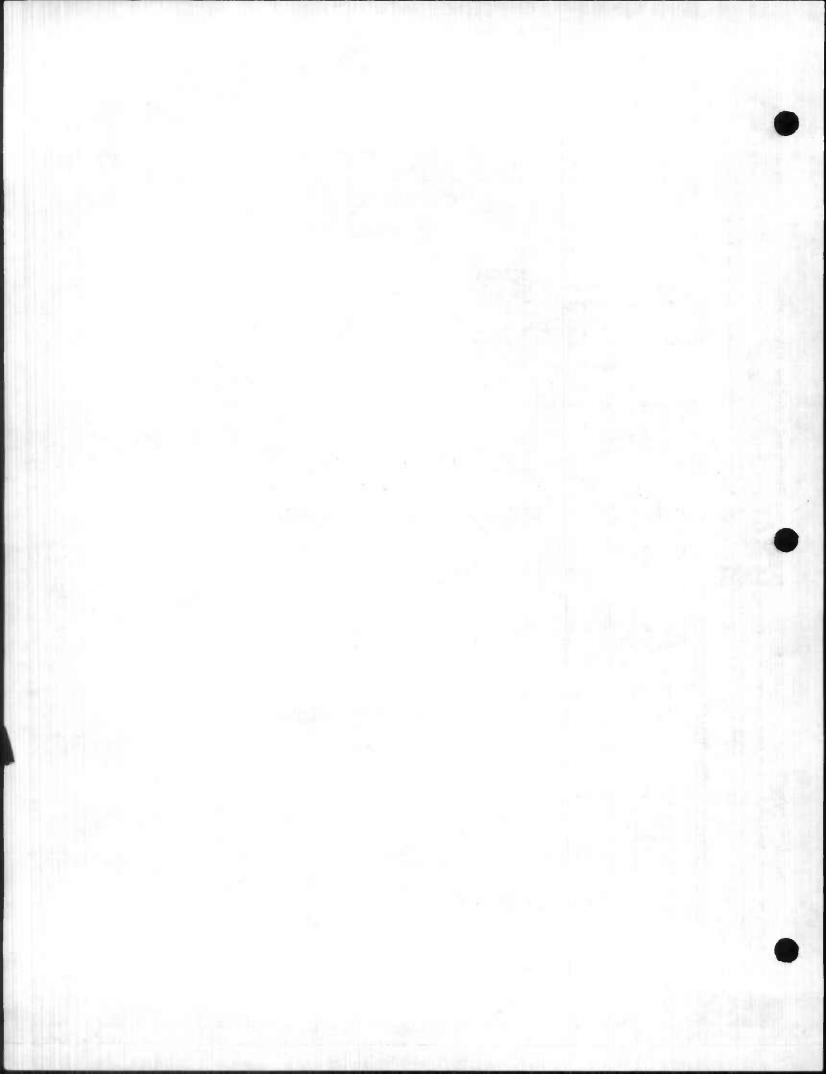
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Registrar

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32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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MD

1 ☑ Yas 2 ☐ No

21206

Approximata Intarvai Between Onset and Death

24b. Wara autopsy findings

available prior to completion of cause of daath?

1 ☐ Yes 2 ☐ No

Physician
/Medical
Examiner

1. Decedent'a Name (First, Middla, Last) Lillian

2. Date of Death Month

3. Time of Death Vosr 3:45pm

Funeral Director

or items 23a or 28a-1 show the Medical Examiner must be notified at Funeral Director 2 "netural". Be Completed

with the Maryland al Hygiene.

filed within 72 hours after death Pages 1 and 2 should be nent of Health and Mental int: If Item 27 is marked or

> Examiner and as the burial-tran been signed by the attending physician should be detached for use as the buria Physician/Medical λq Completed page 2 s Be Medical Certification: To

Maryland 21215-0020 permit. Pages 1 and 2 of Department of Health at Important: If Nem 27 is eny injury or other trauponce. Baltimore. Physician /Medical Examiner The law requires that the death certificate be axecuted Box 68760. P.O. Division of Vital Records, the Hospital or Attending Physicien: on 24 hours that death. The Funeral Director: After this certifical publishy filled in by the funeral director, i

Wilson 2000 Nov. 05, 4e Facility Nema (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Medical Ctn. Baltimore NA 7. Aga (In yrs. last birthday) If Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours 218-07-5722 05-30-20 80 XX Usual Rasidence of Decedani 10c. City, Town or Location 10d. Insida City Limits 10a. Stata MD NA Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2521 East Oliver Street 21213 USA 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Giva 13. Was Decedent of Hispenic Origin? (Specify Yes or No If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Rece - Amaricen indian, Black, Whita, atc. 1 ☐ Never Married 2 ☐ Married 1 Yas 2√ No Specify 3 ☐ Widowed 4 ₺ Divorced Year or Dates: Black 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) Industrial Elementary/Secondary (0-12) Collega (1-4or 5+) 3rd. Grade Custodian Building 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surname) Palmer Goldie John H. Henry 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Iola 5404 Bucknell Road Baltimore, Maryland Hill 20b. Place of Disposition (Name of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata XIX Buriel 2 Cremetion 3 Ramoval from State King Mem. Pk. Cem. 11-10-2000 Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Baltimore, Maryland 21202 lady Wares WM.C.March FH 1101 E.North Avenue 23a. Part1. Entar the disease, or complications that caused the deeth. Do not antar the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediata Causa (Final disaase or condition resulting in death) Congestive Heart Failure Years Dua to (or as a consequence of): Sequentially list conditions, if any, leading to immadiata causa. Enter Undarlying Causa (Disease or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of):

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Part I.

Atheroslerotic Cardiovascular Disease

Cerebrovasular Disease

25. Was casa rafarred to medicei axaminar? 1 Yas 2 No

27. Manner of Death 5 Pending invastigation

6 Could not be

h Co

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28b. Time of

28c. Injury at Work? 1 Yes 2 No

29c. Licensa number

Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 28d. Dascribe how injury occurred

26. Placa of Death (Check only one)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

24a. Wes an eutopsy

performed?

1 Yas 2 No

29b. Signatura and titia of certifiar

1 Natural 2 Accident

3 Suicide

29a Cartifier

4 Homicide

31. Data tiled (Month,

D30377

29d. Date signed (Month, Day, Year) Nov. 13, 2000

23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown

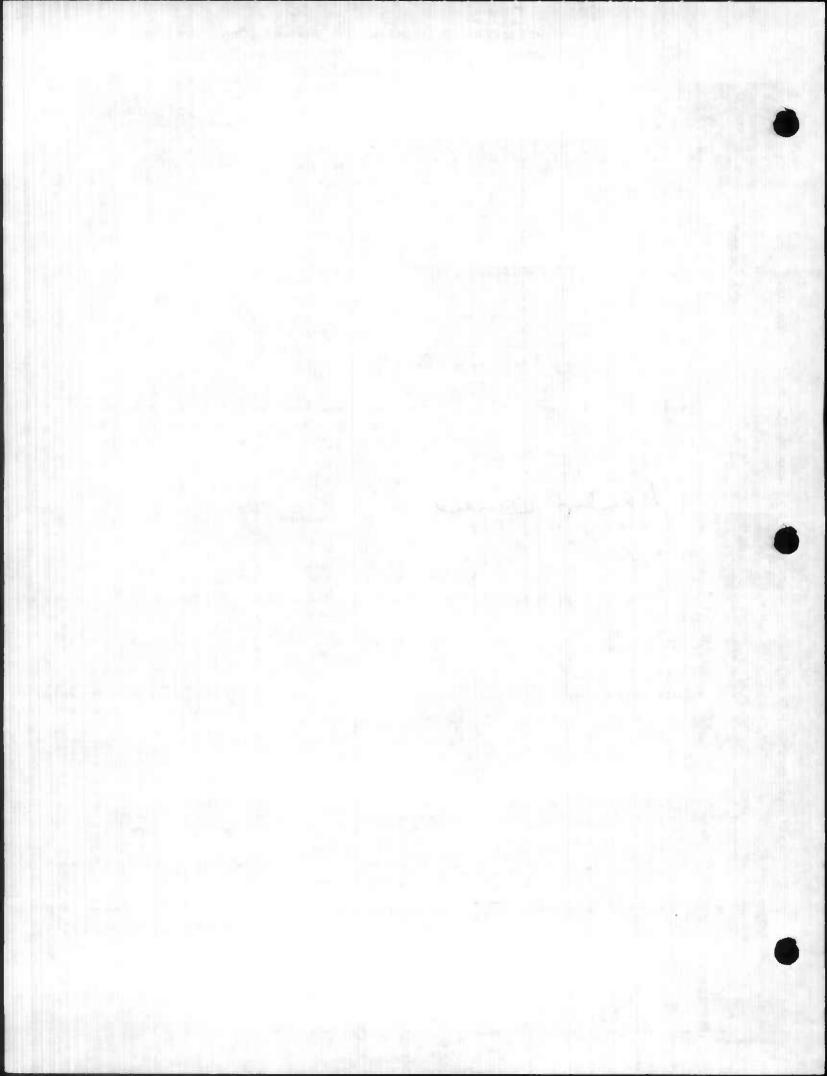
30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

Dr.Robert Μ. Cooper, MD 6503 Park Heights Avenue Baltimore, MD.

State Registrar NOV 1 5 2000

32. Registrar's Signetura Days a some

Boule



Physician /Medical Examiner The law requires that the death certificate be executed Box 68760 the

3

Physician

/Medical

Examiner

Funeral

Director

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ra 23a or 28a-f ahor

Hema

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Il Hygiene.

i. Pages 1 and 2 should be filed vitness of Heelth and Mental Hygie tant: If Item 27 is marked other talury or other traumstic event, in

Department of important: If any injury or page.

filed within 72 hours after

21215-0020

Maryland

Baltimore,

P.O.

Division of Vital Records.

Attanding Physician:

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death.

after death

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Director

Funeral

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Be Completed

Examiner Physician/Medical þ Sign Completed Juneral director. Be Certification: To

25. Was case rafarred to medice! axaminar? 1 Yas 2 No 27. Mannar of Death

28a. Data of Injury (Month, Day Year) 5 Pending Invastigation

28b. Tima of 28c. Injury at Work?

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28d. Describe how injury occurred 1 TYas 2 No

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifier (Check only one)

3 Suicida 4 Homicida

Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basts of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signature and little of certifier Vasantha kumaling 29c. Licensa number

29d. Data signed (Month, Day, Year) OCT. 27Th 2000

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print)

821. N. EUTAWST, # 407, MD 21201 M. VASANTHA KUMAN,

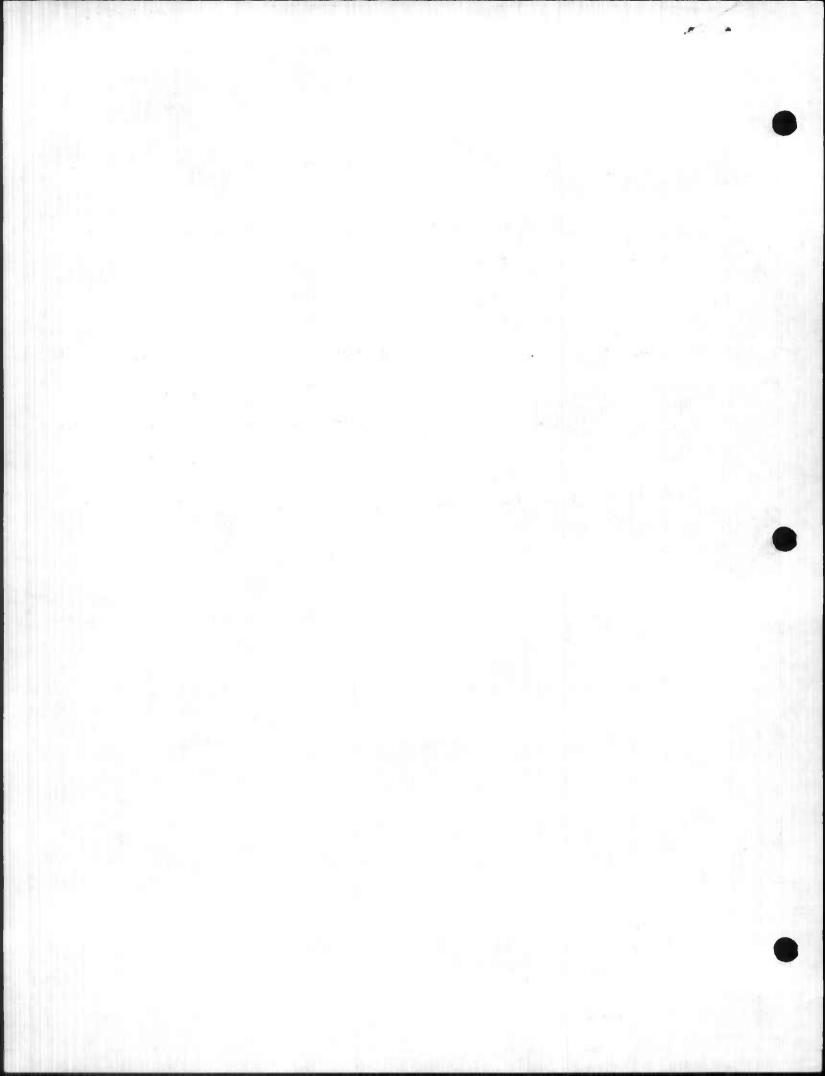
State Registrar

Medical

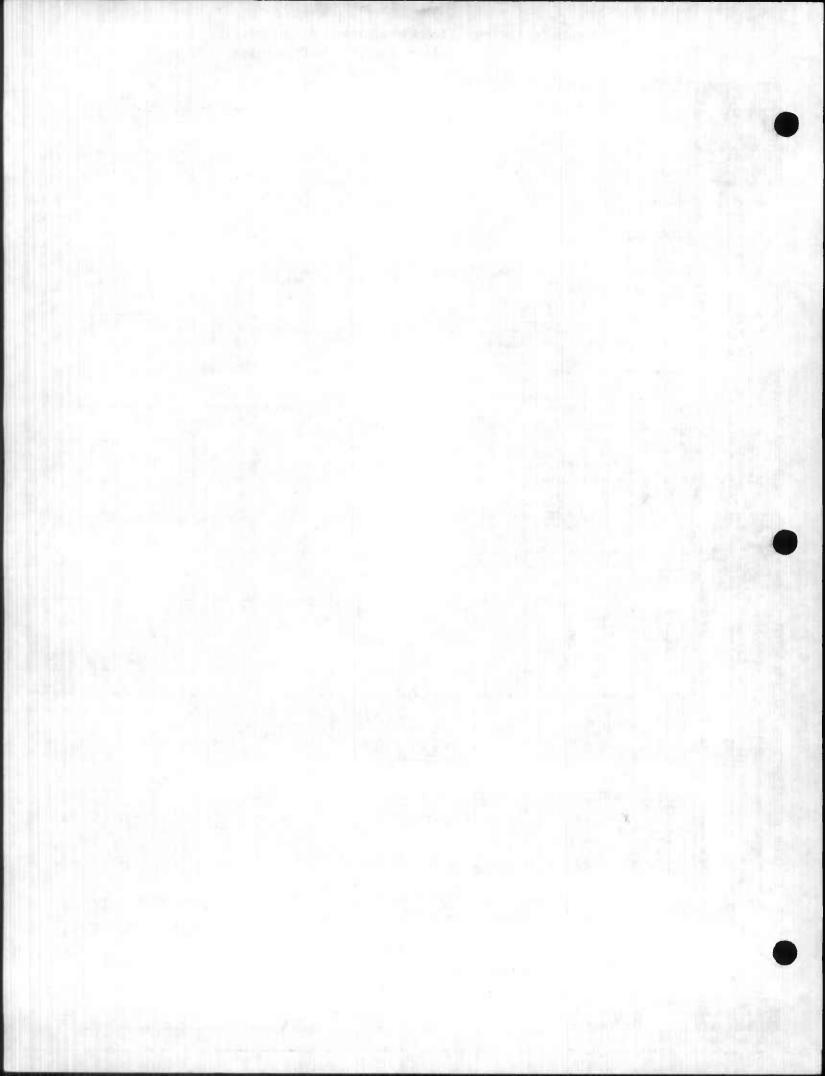
31. Dete filed (Month, Day, Year) NOV 1 5 2000

6 Could not be datarmined

32. Registrar's Signatura



	Decedent's Ner	na (First, Middle, L	nst)		Ce	rtificate of	Death	2. Dete of De	Reg. No.		3. Time of Death		
Physician /Medical		rence Anna						Novembe Novembe	r 8 200	Yaer 0	8:36PM		
Examiner		(If not institution, gi r Care Ruxt		umber)			4b. City, Town, or	Location of Deat	h 4c. County Baltim				
Funeral Director	5. Social Security 216-07-496	Number 6.	Sex 1 M 2)(C) F	7. Age (In yr	rs. last birthday) Yrs.	If Under 1 Year Months Days	TOWSON If Undar 24 Hrs Hours Min.				eca (Stata or Foraign ny) and		
¥	Usual Residence	10b. County		10c. (City, Town or Lo	ocation				10	d. Inside City Limits		
ath with the Marys 23s or 23s-f sho sat be notified at ral Director	Md.	Baltimore		Lu	uthervill	е					1 ☐ Yas 2 🕅 No		
or 28s-fit be notified Directo	10e. Street and No	mber	4.3			10f. Zip Code	18 P B	4	10g. Citizan of Whet Country?				
ath w	17 We	ndslow Rd.				21093				SA			
un sher dost st. or hems 1 Example: mu by Funeri	3 🔯 Widowad	ried 2 Married	Armed F	2 X No		Wes Decedent of It If Yes, specify Cub 1 ☐ Yes 2 ☑ No	dispante Origin? (S an, Mexican, Puar Specify:	Specify Yes or No to Rican, etc.)	Specify	- Amarica k, White, e	itc.		
od within 72 ho pojene. we than "natural, the Medical.	(Spe	15. Decedent's E		()	16e. Dece	dent's Usuel Occup kind of work done DO NOT use retire	pation during most of wo	rking	16b. Kind of Bu	siness/Ind	ustry		
Mary jamu A (A.15-0000) d 2 should be filed within 72 hours at this and Marotal Hygiests, or traumatic swant, the Madical Exam To Be Completed by 8	Etementery/Sec	ondery (0-12)	College	(1-4or 5+)		e Represent			Retail				
tal Hyginad other went, it	17. Fethar's Nema	(First, Middla, Las	()		oci vio	e represent	· · · · · · · · · · · · · · · · · · ·	me (First, Middle	, Maiden Sumam	e)			
Menta by Men	Edwin L	ohmeyer					Elsie	Huggins					
E sho	19e. Informent's h	State, Zip	Code)										
- N - H - 14 - H	Mrs. Susan Lilly/ Daughter 17 Wendslow Rd. Lutherville, Md. 21093 20a. Method of Disposition (Name of Dete 20c. Location - City or Town, State												
peanit. Pages 1 a Department of Hea Montant: If them RP injury or other RDS	1 ☑ Burial 2 ☐ Cramation 3 ☐ Removel from Steta cemetery, crematory or other pleca)												
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3300	1 X	TI	1-8	_		Ruck Tow 1050 Yor	vson Funera k Rd. Tows	1 Home, I son, Md. 2	nc. 1204				
Physician /Medical Examiner physician end streep bearantee per streep physician end end end end end end end end end en	Immediate Cause disease or conditi resulting in deeth; Sequentially list of if any, leading to i cause. Enter Und Cause, (Disease of	on	a b		(or es a consec		SUZ	ok	-]	1	WK		
at the death certificate be associately the death certificate be associately the properties of the strength of the same as the bundal-transpared for use as the bundal-transpared for the same physician/Medical Exer	Cause (Disease of that initieted even resulting in death)	IS The state of th	d	Dua to	(or as a consec	quance of):							
the deal with an ached for hysicia	Pert II. Other algn	ificant conditions	contributing to	death but not re	esulting In the u	inderlying cause gi	ven in Pert I.	23b. Dld	tobacco use cor	ntributa to	the cause of death?		
that the de detached detached								10	Yea 2□ No	3 Prob	ebly #SUnknown		
The law requires that the law requires that page 2 should be de Completed by F								24e. Wes	s an eutopsy omed?	ava cor	re autopsy findings illeble prior to appletion of ceuse death?		
= = = 0								10	Yas 2 No	1 🗆	Yes 200		
Physician: The this certificate ral director, page Co	25. Wes case refe examinar?		Hospitel:			_ 0#	hor: 4	eth (Check only					
P Sign	1 Yes 2 27. Mennar of Dec 1 Natural 2 Accident	th 5 Pending investigation	28a. Dete (Mo		28b. Time o	of 28c. tnju	42 i Kursing i	1	idence 6 Oth		")		
To the Hospital or Attending P within 42 hours after death or to the Funeral Director; After toompletely filled in by the funeral Medical Certification:	3 ☐ Suicida 4 ☐ Homtolde	6 Could not leadermined	28e. Pleo buik	ca of Injury - At ding, etc. (Spe	home, ferm, st	reet, fectory, office			(Street and Numb wn, State)	er or Rura	l Route Number,		
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in Medical Cert	29a. Certifier (Check only one)	10 Certifying P	miner: On the	best of my ki basis of exami nnar steted.	nowledge, deat nation and/or in	occurred et the ti estigation, in my	me, dete end plec opinion, deeth occ	e, end dua to the urred et the time	cause(s) end me , date end ptaca,	nner as st and dua to	ated. the cause(s)		
Nec the	29b. Signeture en	title of certifier	ond ma	gr 510100.	//	29c. Licans	sa number	,	29d. Date signed	d (Month, i	Day, Year)		
- 5 - 0	-	111		1/	/	164	273	6	11-	9 -	00		
	30. Neme and add	00	completed	use of death (II	23e) (Type,	Print)	- TC	war	Mo	17	1204		
State Registrar	31. Dete fled (Mo	th, Day, Year)		Registrer's Sig	neture &	books	/						



00-6423-510 Please Type or Print In Black Indeiible Ink. Assure All Copies Are Legible. ihm State of Maryland / Department of Health and Mental Hygiene BESSIE amend item 23a,27 per me G789 11/30/00 yf Certificate of Death WILSON 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day **Physician** DILSON SESSIE LOUISE NOVEMBER 11, 2000 00:37 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not Institution, giva street and number) Examiner NIA SINAI HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sax 7. Aga (In yrs, last birthday) 8. Data of Birth (Month, Day, Birthplace (Stata or Foreign Country) (Month, Day, Year) MARCH 03, 1940 1 M 2 F Months Days 216-34-7190 Yrs. Director Usual Rasidance of Decedant 10a, Stata 10b. County 10c. City. Town or Location 10d. fnsida City Limits 12 Yas 2 No Directo MARYLAND 10a. Street and Number 10g. Citizen of What Country? 23a Or AYSON STREET 234 NORTH Funeral 12. Was Decedent Evar in U.S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 14. Race - Amaricen Indian, Black, Whita, atc. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 1 Navar Married 2 Married 8 1 Yes 2 No Maryland 21215-0020 Specify by BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working tifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elementery/Secondery (0-12) Collega (1-4or 5+) SEMBLY LINE WORKER HIGRADE 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Sumama) Be is marked of et bluode HARLES SANDERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Pages 1 and 2 BALTIMORE, MD. 21217

20c. Location - City or Town, Stata Hearth Hem 27 OHN CLIFTON AVENUE Baltimore, 20b. Place of Disposition (Nama of camafary, cramatory or other place) 20a. Mathod of Disposition 1 Burial 2 ☐ Cramation 3 ☐ Ramovat from Stata 8 ZION CEMETER 4 ☐ Donation 5 ☐ Othar (Specify) 11-16-00 LANSDOWNE, MARYLAND BROWN JR. FUNERAL HOME 21. Signature of Funaral Sarvice Licensaa 22. Nama and Addrass of Facility JOSEPH H. BROWN -2140 N. FULTON AVE. MD, 2121 23 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death Physician Immediata Ceuse (Finel disaesa or condition rasulting in daath) /Medical ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE **Examiner** Dua to (or as a consequence of) Physician/Medical Examiner Sequantially list conditions, if any, laeding to immadiata cause. Enter Undarlying Cause (Diseasa or injury that initiated avants rasulting in death) Last Dua to (or as a consequance of): The law requires that the death certificate be axecu Box 68760. Dua to (or as a consequence of): 23h. Did tohacco use contribute to the cause of death? P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown þ of Vital Records. 24b. Wara autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? page 2 should Be Completed 2 No 2 No Hospital or Attending Physician: 25. Was cesa referred to medical eyaminar? 26. Placa of Death (Chack only ona) eyaminar: 1 Yas 2 No Hospital: 1 ☐ Inpatiant 2 SER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Certification: To 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Dascribe how Injury occurred 28c. Injury at Work? Division 5 Panding invastigation 1 X Natural 1 Yes 2 No 2 Accident s after death 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Pteca of Injury - At home, ferm, street, factory, office building, atc. (Specify) 4 Homicida within 24 hours Medical 29a. Cartifiar 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and dua to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, dete and placa, and due to the causa(s) and mannar stated.

State Registrar

31. Data filed (Month, Day, Year)

CARON

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29b. Signy

32. Registrar's Signatura backs

and addrass of person who complated ceusa of death (Itam 23a) (Type, Print)

M

DOKE

DHMH 16 Rev 6/95

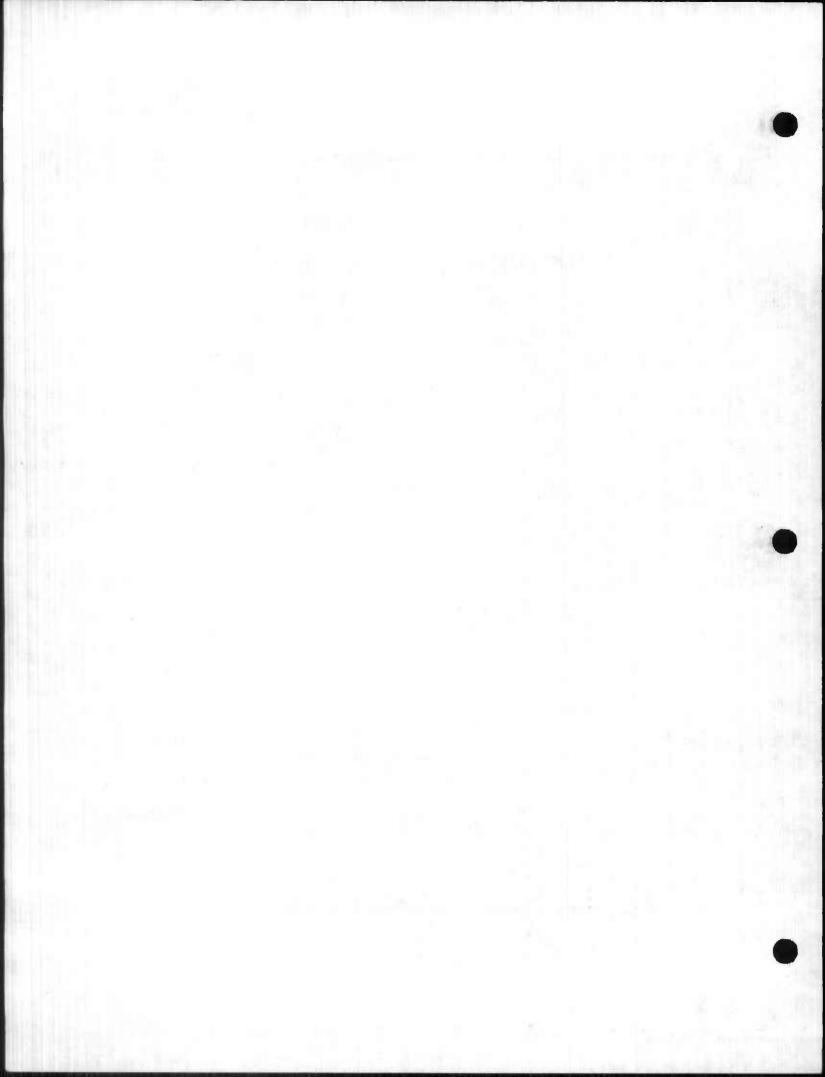
To the

29c. Licensa number OCME

111 Penn Street, Baltimore, Maryland 21201

29d. Data signed (Month, Day, Year)

NOVEMBER 11, 2000



Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 23 Pt. II, per ME, G789, 11/15/00dhb Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Joseph L. White September 27, 2000 1:45 a.m. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Co. Catonsville 603 Maiden Choice Lane - Little Sisters Poor 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Deys Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 10 M 20 F 95 Director 403-64-9650 Sept. 13,1905 | Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Harns 23s or 28s-f show 1 ☐ Yes 2 No Baltimore Catonsville Maryland Directo the Medical Examiner must be nottly 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 601 Maiden Choice Lane 21228 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) Roman Catholic Priest Church 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Surname) Mental Pages 1 and 2 should be White Gibbons Rose Irene Frederick Herbert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) . nt of Health: If Rem 27 I Associated Sulpicians of the U.S. 5408 Roland Avenue Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/2/00 Baltimore, MD Sulpician Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Facility 5305 Harford Road 21214 Baltimore, MD Leonard J. Ruck, Inc. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failura. List only one rause on each tina. Approximate Interval Between Onset and Deeth Physician Immediate Cause (Final disease or condition resulting in death) /Nedical Cardio Vasculas deseas - Azardulia Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Box 68760, Due to (or as a consequence of): P.O. Part It. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Ves 2 No 3 Probably 4 Unknown this certificate has been signed by ral director, page 2 should be detact Division of Vital Records. Be Completed by 24b. Ware sutopsy findings evailable prior to completion of ceuse of death? in joint disease 24a. Was an autopsy performed? 1 Yes 2 No oc Osteoporosis 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes ZENO Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred s after death.

J Director: After to do in by the funers 1 Matural 2 Accident 5 Panding 1 Yes 2 No Investigation 6 Could not be 3 ☐ Suicide 28a. Ptace of Injury - At homa, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicida To the Hospital or A within 24 hours after To the Funeral Dire-completely filled in b 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29a. Cartifiar 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture end title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wekens AVT. BALTIMORE MD 21229

Registrar **DHMH 16 Rev 6/95**

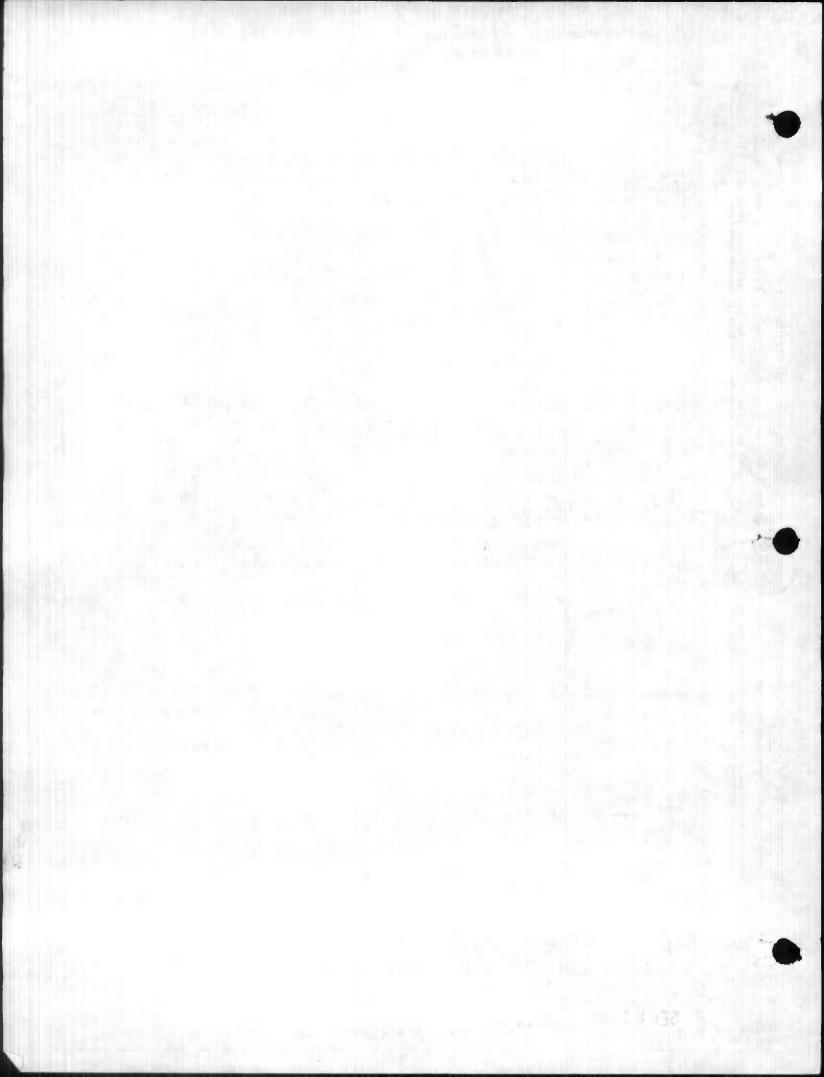
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31. Date filed (Month, Day, Year)

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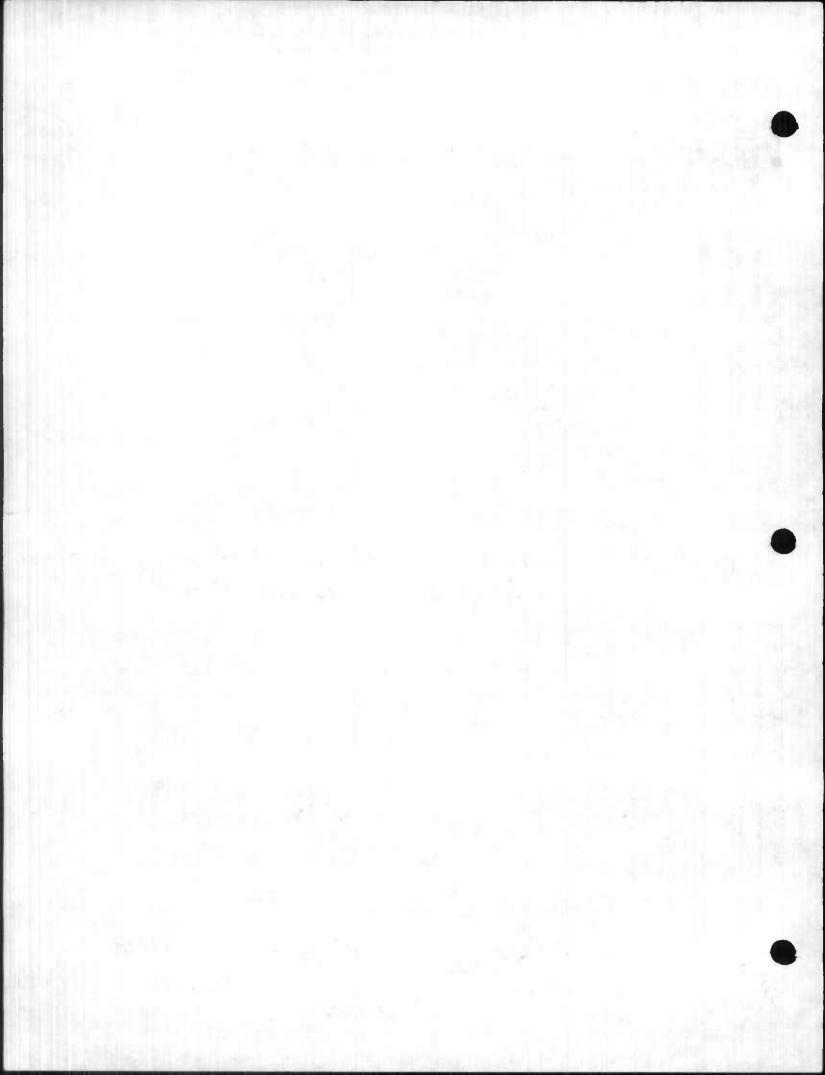
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32. Registrar's Signature



MARY FRANCES WITT

		Otato (Ji iviai yiai k		tificate of	lealth and M Death		Reg. No.	0 3635			
Physician	1. Decedent's Nema (First, Midd	ile, Last)					2. Dete of De Month	eth Day	3. Time of			
/Medical	Mary Frances						Novembe		000 2:25			
Examiner	4a Facility Neme (If not institution	111011110111111111			4	lb. City, Town, or L	ocation of Deati	Death 4c. County of Death Baltimore				
Constant of	Edenwald Retir	ement Cen	7. Age (fn yrs. le	ast birthdev)	If Under 1 Year	Towson If Undar 24 Hrs.						
Funeral Director	213-52-8811	1□M 20 F	90	Yrs.	Months Days	Hours Min.	8. Data of Bir (Month, Da 05-23-]	1910	Iowa			
} =	Usual Residence of Decedent 10a. Stete 10b. Count	у	10c. City	, Town or Lo	cation				10d. Inside Ci			
me 23e or 28e-f show finant be notified at neral Director	Maryland Balt	imore	Т	owson					1 ☐ Yes			
r hame 23e or 28e4 e	10e. Street and Number				10f. Zip Coda			10g. Citizen of V	Whet Country?			
23s c	800 Southerly	Road			21286			United	States			
The First	11. Meritel Status	12. Was Dec Armed F	cedent Evar in U,S orces?	S. 13. V	Wes Decedant of H Yas, specify Cuba	ispanic Origin? (Span, Mexican, Puart	pecify Yes or No Rican, etc.)	14. Rac Bled	a - American Indien, ck, White, etc.			
by	1 Never Merried 2 Ma 3 Widowed 4 Divorce	rried 1 Yes If Yes, G Yaer or I	210 No ive Detes:		Yea 2 No	Specify:	Specify: White					
ated per		ent's Education est grede completed	king	16b. Kind of Bu	usiness/industry							
and the Hydiene. evant, the Material Be Completed	Elemantary/Secondary (0-12)		(1-4or 5+)	Home M	OO NOT use retired	1)		0	wn Home			
(D) & GE	17. Father's Neme (First, Middle Ira Daniel Lut					.18. Mothera Nam Myrtle		, Maiden Sumerr	na)			
Health and Mentan 27 is marke other traumatic	19e. Informent's Neme/Reletion	iship (Type, Print)		19b. Mailin	g Address (Street	end Number or Ru	ral Route Numb	er, City or Town,	Stata, Zip Code)			
n 27 l	Marilyn W. Sedl	ack(Daugh	ter)	4 Ain	tree Roa	d Towson	, Maryla	and 212	86			
of He oth	20a. Method of Disposition 1 Durial 2 Cremetion	2 DRamaual from		ece of Dispo	sition (Nema of natory or othar pled	ca)	Date	20c. Location -	City or Town, Stete			
nent of Interest o	4 Donation 5 Other (Specify)	Ba1	timore	-Washtin	gton Cre	n. 11-1	4 Laurel	, Maryland			
Department of Health a Important: If item 27 is any injury or other trea	21. Signature of Funeral Service	Licensee		Br 21	Neme end Addre adley-As 34 Willo	ss of Fecility hton-Mat	thews Fu	uneral H	ome, Inc.			
	23a. Part1 Enter the chease of shoot, or heart failure. Life	complications that	caused the death	7					Approximet Interval Bet			
nysician	and a second or	1				,			Onset end			
Medical kaminer	Immediate Cause diseesa or condition rasulting in death)	· Acu	HR Let	+ mid	dle Cere	bral Art	en Str	oke	one			
-		1.	Due to (or	es a conseq	uenca of): Cardio	1/100 10	De.	PLICE				
an and inal-transit Examiner	Sequentially tist conditiona,	b	Due to (or	as a conseq	uanca of):	Vascula	7 113	CEISC				
	if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury											
d by the attending physicit etached for use as the bu Physician/Medical	Cause (Disease or Injury that initiated events resulting in deeth) Lest	c	Dua to (or	as a conseq	uenca of):							
Med Med	resoluting in deeting Less											
or use		0										
the at the sale	Pert II. Other atgniftcant condit	ions contributing to d	death but not rasu	lting in the ur	ndarlying cause giv	an in Pert I.	23b. Did	tobacco uss co	ntribute to the cause			
signed by the d be detached by Physic	Epilepsy						10	Y88 2□ No	3 □ Probably 4 🖫			
te has been signed by the attending physicit page 2 should be detached for use as the bucompleted by Physician/Medical	143	0			A-L	14 14 14	24a Was	s en eutopsy	24b. Were autopsy			
should should	Propessiv	ie Parapi	ures is					ormed?	available prior			
page 2 should	Progressiv Dement	•					0	Yes 2000	of death?			
	Dement	ia				00 Dia			1 ☐ Yas 2 ☐			
s certificate has director, page 2 To Be Comp	25. Was case reterred to medic axaminer? 1 Yes 2 No	Hospitel:	Inpatient 2	EB/Outpation	t 3 DOA Oth	26. Place of Dec		idenca 6 DOth	ner (Snecity)			
eral d	27. Menner of Death	28e. Date	of tnjury oth, Dey Year)	28b. Time of				how injury occur				
	1 Naturet 5 ☐ Pand 2 ☐ Accident Invas	ing (Moi tigetion	ntn, Dey Year)	Injury		Yas 2□No						
e fur e	3 ☐ Suicide 6 ☐ Could	d not be mined 28e. Place build	e of Injury - At ho ding, etc. (Specify	me, ferm, str	eet, factory, office		28f. Location (City or To	(Street and Number, Stete)	ber or Rurel Route Nun			
after death. Director: After th J in by the funeral ertification:	4 Homicide deter			Andre desemb	occurred at the time	me, data and place	, and dua to tha					
24 hours after death. Funeral Director: After to the funeral diled in by the funeradical Certification:	29a. Certifier 1 Certify (Check only 2 Medica		basis of examinet				rred at the time,	, date end pleca,	and dua to the ceuse(
within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be	29a. Certifier 1 Certify	f Examiner: On the I				pinion, deeth occu	rred at the time,	29d. Date signe	ed (Month, Day, Year)			
within 24 hours after death. To the Fureral Director: After completely filled in by the fur	29a. Certifier 1 Certify (Check only one)	f Examiner: On the I	basis of examinet		vestigetion, in my o	pinion, deeth occu	rred at the time	29d. Date signe	ed (Month, Day, Year)			
within 24 hours after death. To the Funeral Director: An completely filled in by the fur Medical Certificatio	29a. Certifier 1 Certify (Check only one)	of Examiner: On the band mei	basis of examinetinner stated.	ion and/or inv	29c. Licens	e number		29d. Date signe	od (Month, Day, Year)			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Day AN DERSON MAGNOLIA NOVEMBER 13 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE RANDALISTUNIV NORTHWEST HISPITAL CENTER 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth Months Devs Hours Min. (Month, Day, Year) 5. Sociel Security Number 6. Sex Birthplace (State or Foreign Country) Deys Months 1□M 20 F Yrs. 83 09-18-17 NORTH CAROLINA 238-64-7649 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No BALTO. RANDALLSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 4214 HOLBROOK RD 21133 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ Yoo If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 ☐ No Specify: BLACK 3 DtWidowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) DOMESTIC 1.2 HOMEMAKER 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) LAMAR BELL MEG SMITH 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) EARL ANDERSON, SON RANDALLSTOWN, MD 21133 4214 HOLBROOK RD, 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 111-20-00 ROXOBELL, NC 4 □ Donation 5 □ Other (Specify) KELFORD CEMETERY 22. Neme and Address of Facility HOWELL FUNERAL HOME 21. Signature of Femeral Service Licensee Herve 4600 LIBERTY HGHTS AVE, BALTO, MD 21207 Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete fntervel Between Onset and Deeth Immediate Cause (Final disease or condition resulting in deeth) ARTERIOSCLEROSIL CARDIOVASCULAR DISTAST Due to (or es e consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of) Due to (or es e consequence of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? 1 ☐ Yes 213 No 1 ☐ Yes 2 ☐ No 25. Wes case reterred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient ②□ SER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury et Work? 1 Neturet 5 Pending investigation 1 Yes 2 No 2 Accident

Examiner The law requires that the death certificate be executed ician and burial-trans physician s the buria Box 68760. P.O. Division of Vital Records. page 2 should this After

Physician

/Medical

Examiner

Funeral

Director

28a-f

finer mant be n

"natural", or

Hygiens.

Pages 1 and 2 should be fit ment of Health and Mental H lant: If them 27 is marked off jury or other traumatic even

Department of Important: If any injury or page.

Physician

/Medical

Examiner

21215-0020

Baltimore, Maryland

Directo

Funeral

ð

Completed

Physician/Medical þ Certification: To Be Completed

or Attending Physician: death. 24 hours after deat Funeral Director: 3 Hospital

> State Registrar

Mithin 2 8

> 31. Dete filed (Month, Day, Year) MON I & SDOD

3 Suicide

4 Homicide

(Check only

29b. Signeture end title of certifier

6 Could not be

fred Faly, MD

32. Registrer's Signeture

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

29c. License number 0 2 497 0

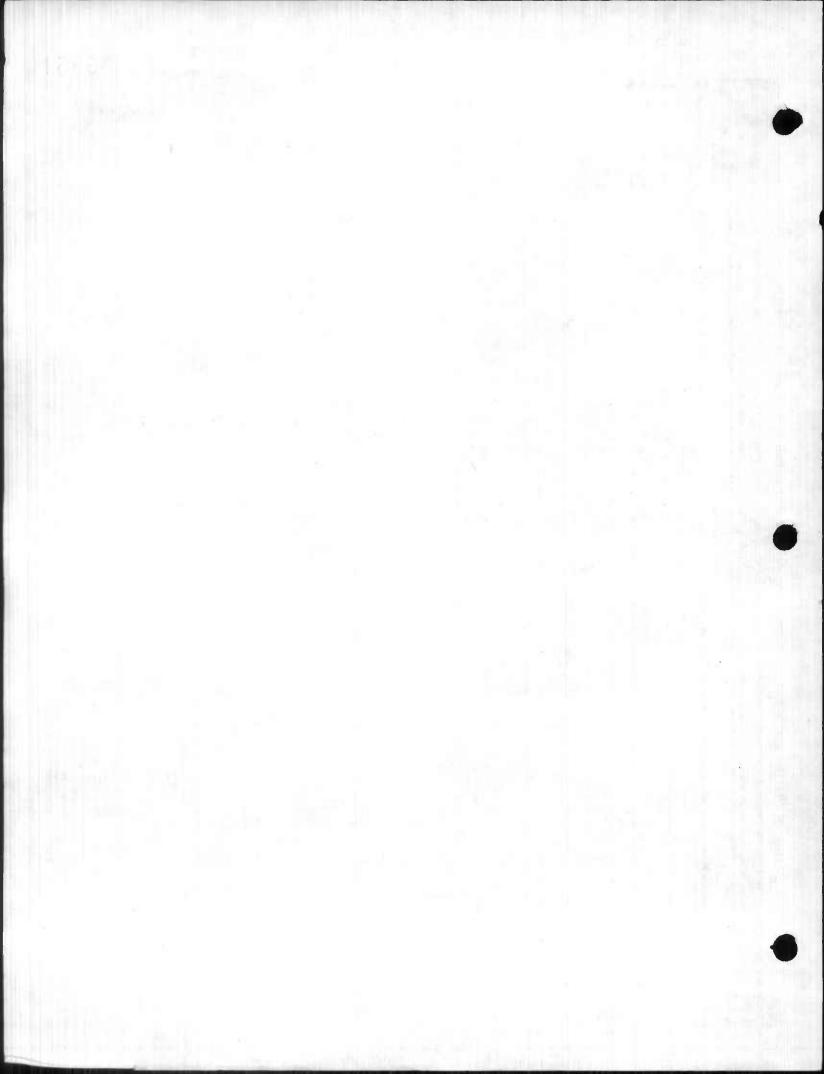
Dankas

Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. 29d. Dete signed (Month, Day, Year) NOVEMBER, 13,2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
CLIFFORD FARER, MD NORTHWESS HOSPITAL CENTER, RAMPALISTOWN MARYLAND
21133

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

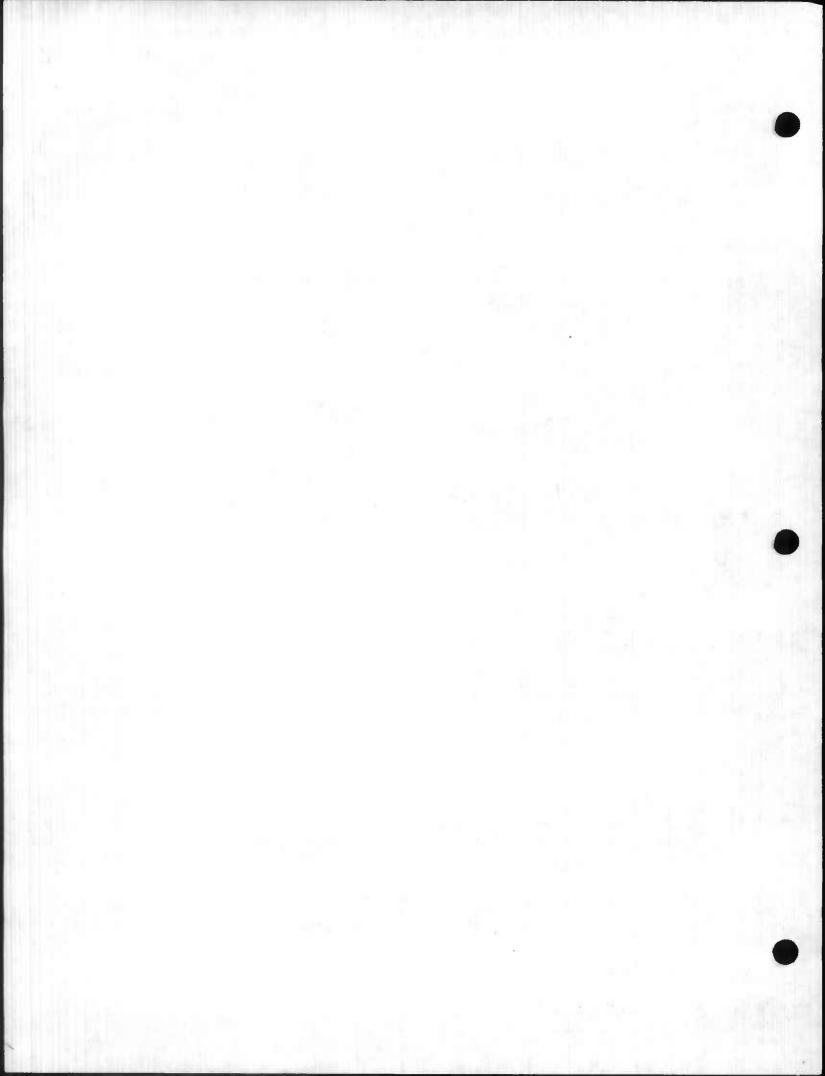


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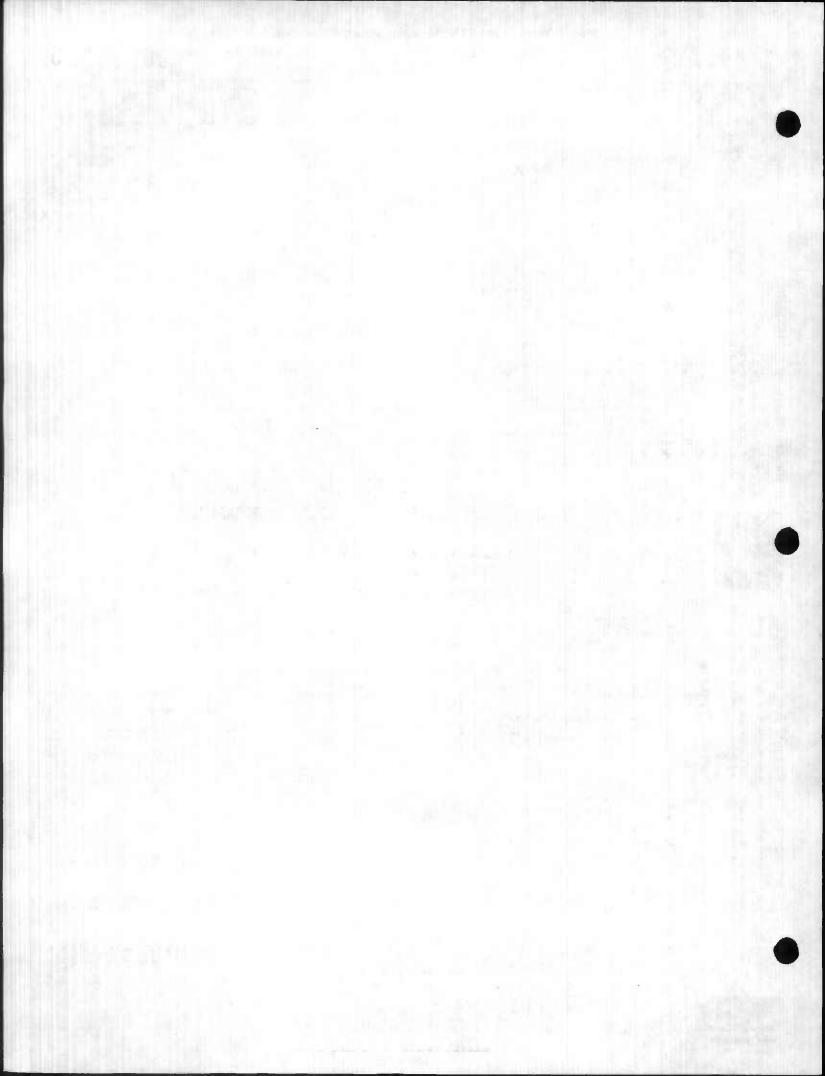
amend item 23a,b,27,23b	per me G/90 12/7	700 yerunc	ale UI	Dealit	2. Dete of Dec	Reg. No.		3. Tima of Death		
					Month	Dey	Year			
Sidney		Anderson		4b. City, Town, or I	NOVEMB			4:37P.M.		
4a Facility Name (If not Institution, give	street end number)									
ST. AGNES HOSPITAL 5. Sociel Security Number 6. Se	x 7. Age (In yrs.	last hirthday) If Un	der 1 Yeer	BALTIMOR If Under 24 Hrs.		th 9. Birtholace (State or Foreig				
	M 20F 31	Yrs. Monti	ns Days		Date of Birth (Month, Day, Year) O1-16-69 Birthplace (State or Fore Country) MD					
Usual Residence of Decedent	. 31				101-16	-69	MD			
10a. State 10b. County		ity, Town or Location						Inside City Limits		
MD NA	Bal	ltimore						XXYas 2 No		
MD NA 10e. Street and Number		10f.	Zip Code			10g. Citizen of W	hat Country	?		
3527 Old York 11. Merital Status XXNever Merried 2 Merried	Road	21	218			USA				
11. Merital Status	12. Wes Decedent Ever in L Armed Forces?	J,S. 13. Was De	cedent of I	Hispanic Origin? (S een, Mexican, Puert	pecify Yes or No-	14. Race	- American			
XNever Merried 2 Merried	1 Yes 2 XNo		2 ₹ No							
3 Widowed 4 Divorced	Year or Dates:		20110	ороспу.	Specify: B			K		
15. Decedent's Ed	ucetion (e completed)	16e. Decedent's L (Give kind of	pation during most of world)	king	16b. Kind of Bu	6b. Kind of Business/Industry				
Elementary/Secondary (0-12)	College (1-4or 5+)					L.A.I	I. truction Co.			
12th Grade	NA	Constru	ictic	18. Mother's Nar	and Clark Adjustella			on Co.		
17. Father's Name (First, Middle, Last)	Privette				ne (First, Middle,					
Eddie			101	Mary	Coleman Rural Route Number, City or Town, State, Zip Code)					
19a. Informant's Name/Relationship (7) Paula M. Jor				ork Road						
20a. Method of Disposition		Place of Disposition (JEN ROGO	Date	20c. Location -		Ciata		
N Buriet 2 □ Cremetion 3 □	Removal from State	cemetery, crematory	or other pla					MD.		
4 Donation 5 Other (Specify					7 11-18-2000 Catonsvill					
21. Signature of Funeral Service Licenter	a Class) 22. Name	ena Adar	ess of Fecility	altimo	re, Mar	yland	21202		
quisitett	0 0000			cch FH 1						
23e. Pert1. Enfer the disease, or comp shock, or heart failure. List only	licefions that ceused the dea ne cause on each line.	th. Do not enter the r	node of dy	ing, such es cardiac	or respiratory a	rrest,	ln:	pproximate terval Between nset and Death		
								iset sild Death		
Immediate Cause (Finel disease or condition resulting in death)	a. CARDIAC ARRHY	THMIA		STORY.						
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	HYPERTENSIVE H	or as a consequence	of):	SOCTATION I	าาน					
	b. HYPERTHYROIDI	SM DISEASE	IN AO	POCTATION M	TIU					
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events	Due to (or as a consequence	of):							
Cause (Disease or Injury	c						1			
Cause (Disease or Injury that Initiated events resulting in death) Last	Due to (or as e consequence	of):							
Part fl. Other significant conditions co	d									
					L con mid					
Part fl. Other significant conditions co	ntributing to death but not re	sulting in the underlyii	ng ceuse g	iven in Pert I.		Yes 2 No	~	ne cause of death bly 4 ☐ Unknow		
					لطا	Y88 2 100	9 Probal	any 4 Dilikilon		
				,		an autopsy	24b. Were	autopsy findings		
					perio	ormed?	comp of de	able prior to pletion of cause		
					×6.	•□•				
			_		1/2		1)81	/es 2□ No		
25. Was cese referred to medicel examiner?	Hospital:	·		ther:	ath (Check only o		400 16 1			
120 Yes 2 No	1 ☐ inpatient 2☐	ZER/Outpatient 3C 28b. Time of	DUA	4 Li Nursing r	lome 5 Resi	dence 8 LIOth how injury occur				
1 Natural 5 Pending	(Month, Day Year)	Injury	28c. tnju Wo	ork?]Yes 2□No		,,				
3 Suicide 6 Could not be	28e. Place of Injury - At I				28f. Location (Street and Numb	er or Rural F	Route Number,		
4 Homicide determined	building, etc. (Spec	ify)	,,		City or To	wn, State)				
	elcian: To the best of my kn Iner: On the basis of examin									
29a. Certifier (Check only one) 1 Certifying Phyone) 2 Medical Examone) 29b. Signature and title of certifier	and manner stated.		29c. Licen	ise number		29d. Date signe	d (Month, Da	v. Year)		
	V Min	Fig. 1		C.M.E.						
1/1	1		0.	C.M.E.		NOVEMBE	13,2	000		
30. Name and address of person who co	empleted cause of death (Ite	A	Danie	Ctonst	Do7+:	mo M	E.m.a.f.	21201		
11/11/124 (1.	NIPP LIC, ING	// III	"Eeul	Street,	DOTTINO	re, Mar	DIDT	41401		
31. Date filed (Mantha Pay, Year)	32. Registrar's Sign	natura 1	oork	2.5						



State of Maryland / Department of Health and Mental Hygiene 0 36353

	Certificate of Death Reg. No.											
	1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Day Yeer											
Physician	Mary	S.		Amato				Nov.	13, 2	000 Veer	0946	
/Medical	4e Facility Name (If not institution,			Timacc		4b. City, To	wn, or L	ocation of Death	-			
Examiner	106 S. Taylor				50	Esse	v		* 0			
	-		Age (In yrs. last birth	day) If Unde	r 1 Yeer	If Under		8. Date of Birtl		timo 9 Birtho		
Funeral Director	214-12-4608	1□M 2 X F		Months	Deys	Hours	Min.	8. Date of Birtl (Month, Day Oct 1.3	3,1921		lace (Stete or Foreig stry)	
Director	Usuai Residenca of Decedent		13					000 1.	1721	IAI	d.	
ž.,	10a. Stete 10b. County										0d. Inside City Limits	
4 P	Md Dolle							1 ☐ Yes 2 Å				
notifie recto	Md. Balti	more	Essex	404.70	0-1-			10g. Citizen of What Country?				
5 9 5	10e. Street and Number				Code							
Tal Last	106 S. Tatlo	r Ave.		2	122	1			USA			
E E	11. Marital Stetus	12. Wes Deceder Armed Force	nt Ever in U,S.	13. Was Dece	dent of H	lispanic Ori en, Mexicai	igin? (Sp	ecify Yes or No- Rican, etc.)	14. Rac	a - Americ ck, White,		
F. E.	1 Never Married 2 Marrie			1□ Yes		Specify:						
D Par	3 Widowed 4 □ Divorced	Yeer or Date:	s:	10 165	2 140	зреспу.			эресп)	Whi	te	
ygiene, ver than "natural, rt, the Medical, Completed	15. Decedent		16a. [Decedent's Usu	al Occup	ation	4 -4		16b. Kind of B	usiness/Inc	dustry	
ple ple	(Specify only highes Elementary/Secondary (0-12)	College (1-4o		Give kind of wo life. DO NOT u	se retire	aunng mos d)	t or work	ing				
and H	8 yrs.	College (1-40		ousewi	fe				Own Ho	ome		
	17. Father's Name (First, Middle, L	ast)				18. Moth	er's Nam	e (First, Middle,				
eve o	Antonio Rest	auro				Con	rati	a Cape	11:			
To To	19a. informant's Name/Relationsh		100	Mailine Address	0 /04			-	-	Town, State, Zip Code)		
2 2 2					-							
m 27	Anthony Amato	2			race	, EC	gewood	-				
25.7	20a. Method of Disposition	3 DRemoval from Stat	20b. Plece of I	other plan	ce)	1	Nov.17	20c. Location -	City or To	own, State		
and	1 Buriai 2 Cremation 3 Removal from State Oaklawn Cemetery 2000										Md	
Importa	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home of Dun 7110 Sollers Point Rd. Dunda											
d d v d	b/ hat have	, (ne	2010.	Conne	lly	Fune	eral	Home	of Dur	ndall	P.A.	
	23a Party Enter the disease and	omplications that save	and the death life in	7 I I U	SOL.	lers	Pol	er receiratory as	Dunda	alk,	Approximata	
	23a. PertY. Enter the disease, or shock, or heart failure. List	only one cause on each	iine.	a enter the mo	de or dyn	ig, such as	cardiac	or respiratory at	1001,	!	Interval Between Onset and Death	
ysician		^	T	n	0	0		1		1	200	
Medical aminer	Immediate Cause (Finel disease or condition resulting in death) A cute intra cerebral hemorrhage											
	resulting in death)		Due to (or as a co	onsequenca of)	:				1		7	
= E	Chronic hypertinoise candiovascular choses										1 grs.	
Erans											0	
s the burie edical E	Cause (Disease or injury that initiated events											
the se	resulting in death) Last		240.0000									
attending pl for use as t iclan/Med		d								<u>_</u>		
for in								1				
# # S	Part II. Other significant condition	-	but not resulting In	the underlying	cause giv	ren In Pert	l	23b. Did 1			o the causs of death	
Ph Jeles	Viabetes m	elletus						10'	Yes 20 No	3 ☐ Pro	bebly 4 Unknow	
58 2										T		
page 2 should Completed								24a. Was perfo	an eutopsy rmed?	av	ere sutopsy findings ailable prior to	
2 sh					9		-				mpletion of cause death?	
page 2								101	res 200 No	11	☐ Yes 2☐ No	
o. p	25. Was case referred to medical					00.01	n of 5		1			
certificate irector, pag	examiner?	Hospitel:			Ot Oth			th (Check only o				
S P	1 Yes 2 No	1 L Inpa			UA	4 L N	ursing H	ome Series			(y)	
After the funeral	27. Manner of Death 1 Natural 5 Pending	28e. Date of Ir (Month, I	njury 28b. Ti Day Year) Inj		28c. Injui Wo			28d. Describe I	now injury occur	теа		
Director: A l in by the fu ertificati	2 ☐ Accident investig	ation		М	1 🗆	Yes 2	No					
th by	3 Suicide 6 Could n	ned 259. Place of	Injury - At home, fan etc. (Specify)	m, street, fector	ry, office			28f. Location (5 City or Tox	Street end Numi	ber or Rure	al Route Number,	
		Durang,	oto. (opoony)						,,			
in fille	29e. Certifier 1□ Certifying	Physician: To the bes	st of my knowledge,	deeth occurred	et the tir	me, date ar	nd plece,	end due to the	cause(s) and m	enner es s	tated.	
plately fill edical		xaminer: On the basis and menner	of examinetion and									
Me Me	29b. Signature and title of certifier	410 11011101	Stotou.	29	c. Licens	se number	-		29d. Date signe	d (Month.	Dav. Year)	
6.8	T 0	1	100	. 0	20	76	2 2				15,2000	
-11	J. C. 2000	m offer	Nan, 1	N.O.	R				(4,00	7000	13/2000	
110	30. Name and address of person v	no completed cause o	death (Item 23a) (T	ype Print)			1	0.		4.5	2	
) \	1. CROSSAN C	MAYONOL (2112	- Dun D	MIL	- AH	1E	BA		WD.	11222	
State	31. Date filed (Month, Day, Year)		strer's Signeture		0			- / -				
Registrar		M	and d	4 1	am A	11						

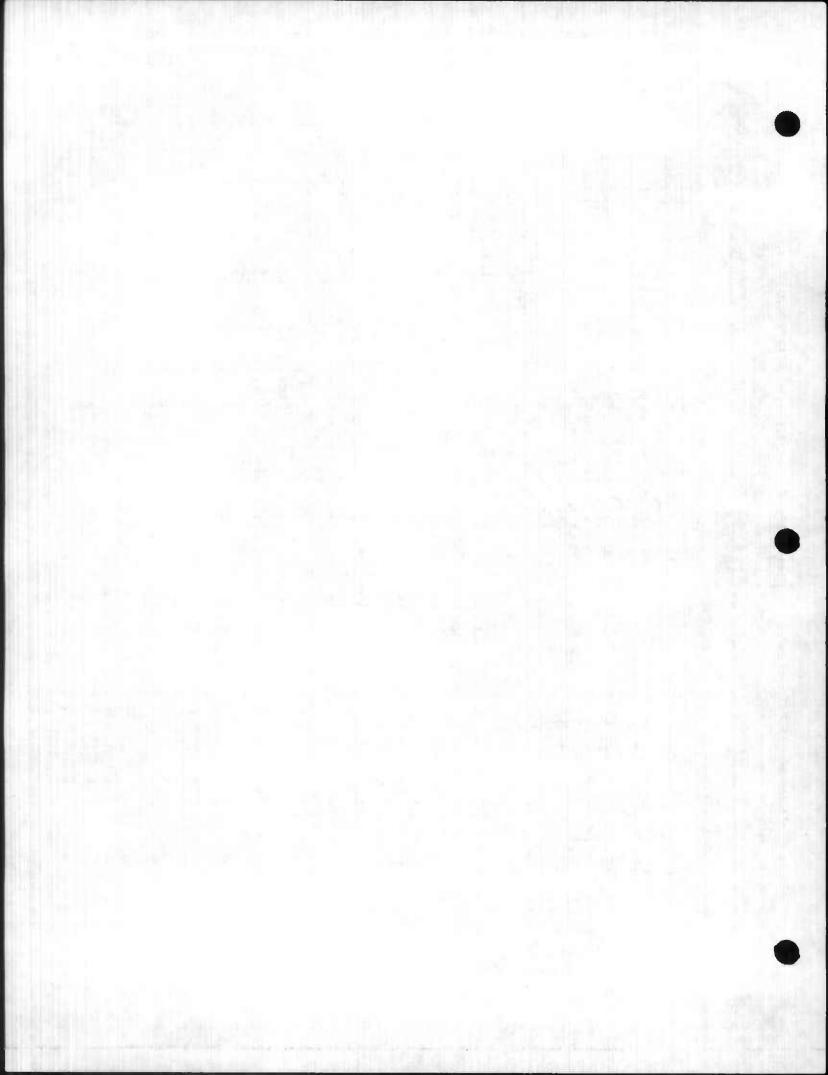
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State of Maryland / Department of Health and Mental Hygiene 0 36354

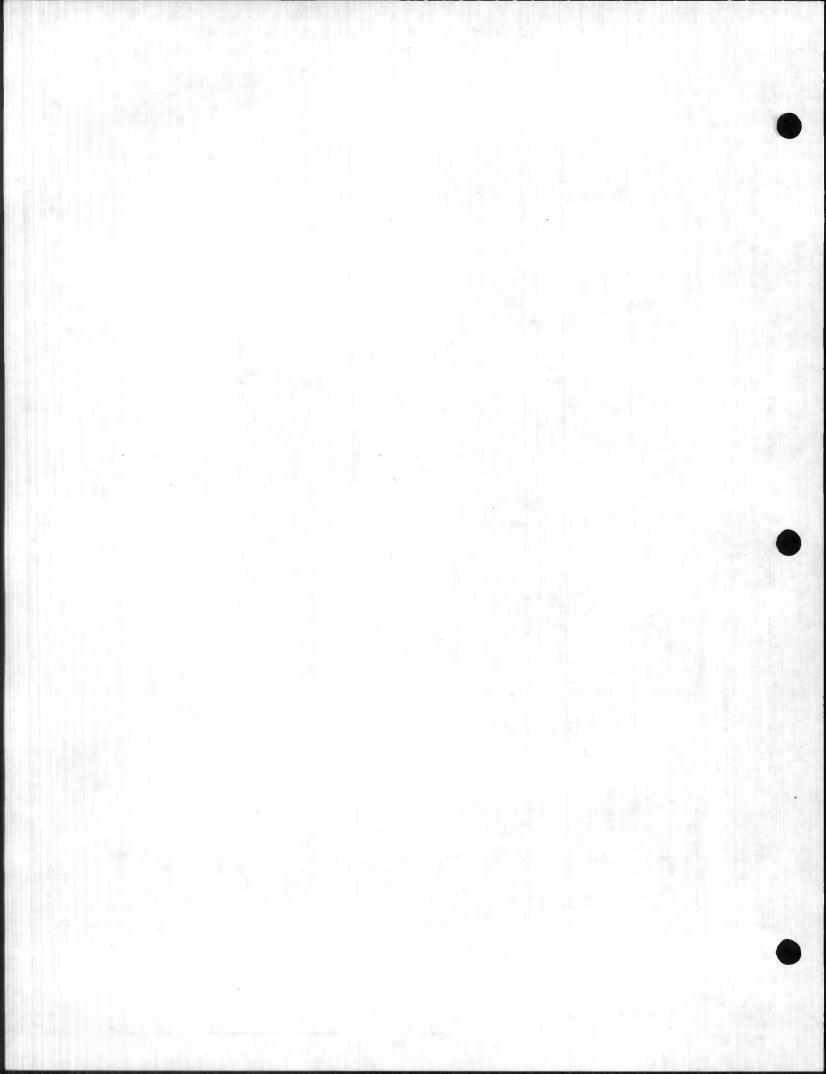
					Certific	cate of	Death	·······································	Reg. No.	30334					
	Physician	1. Decedent's Name (First, Mid						2. Date of Dee Month	Day	3. Time of Dea					
	/Medical	John Ales							er 13, 2		M.				
À	Examiner	4e Facility Name (If not instituti						Location of Death	1						
100		Lorien Frank					Baltimon		N/						
_	Funeral Director	5. Sociel Security Number 218-01-6082	6. Sex 7. A	ge (In yrs. last bir 85		Inder 1 Year oths Days	If Under 24 Hrs Hours Min.		1915	9. Birthplace (State or Fo Country) Virginia	reign				
2	1.	Usual Residence of Decedent 10a. Stete 10b. Count	v	10c. City, Tow	n or Location					10d. Inside City Li	imits				
e Maryta	or 28a-f show be notified at Director	MD N/		Baltin						1 Types 2					
D WITH D	23a or 28a-f s at be notified al Director	10e. Street and Number 4501 Belair F	Road 2ND Floo	r	100	f. Zip Code 2120	6		10g. Citizen of W	hat Country?					
21215-0020 d within 72 hours after dea	Examiner m Examiner m	11. Marital Status 1 Never Married 2 Ma 3 St Widowed 4 Divorce	If Yas Giva	7		Pecedent of H specify Cuba as 2 1 No		Specify Yes or No- to Rican, etc.)	Black	- Amarican Indian, , White, etc. White					
22.0	and and better	15. Decede	ent's Education lest grade completed)	16a.	Decedent's	Usual Occup	ation	dring	16b. Kind of Bus	siness/Industry					
121	we than "nature t, the Medical Completed	Elementary/Secondary (0-12)		5+) T	aborer	OT use retired	during most of wo	ining	Cemete	2717					
D-00		17. Father's Name (First, Middle	(Lic	aborer		40. Mark ada Na	me (First, Middle,							
and	Be sed						Lucy		Maidell Surname	"					
P de	To	Henry Alshir 19a. Informant's Neme/Reletion		106	Mailing Ade	trace /Stract			e City of Tourn	State Zin Code)					
, Ma	n 27 is r	James Alshire		4.	lair R	Street and Number or Rural Route Number, City or Town, State, Zip Code) r Road 2nd Floor Baltimore, Maryland 2120									
Pages 1	mt if lies ary or oth			20b. Place of cemeter Oakla			e)	Date 11/15/00		City or Town, Stete Ore, Marylan	ıd				
Balt	importa any inji	1 Souriel 2 Cremation 3 Removal from State Oaklawn Cemetery 11/15/00 Baltimore, Marylan Oaklawn Cemetery 22. Name end Address of Facility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206													
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D, exacute	physician and s the burist-transit edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events													
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P.O.	signed by the a lid be detached i d by Physic			out not resulting it	in the underly	ing cause giv	on in raidi.		Yes 2□ No	3□ Probably 4 Duni					
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of Vital Records, P.O. Box Physician: The law requires that the death cert	shou	In s	As					24a. Was perfo	an autopsy med?	24b. Were autopsy finding available prior to completion of caus					
I Re	has pe 2							10)	es 2 No	of death?					
tal	certificate rector, pag	25. Was case referred to medic	al				26. Place of De	ath (Check only o							
of Vita	0 D	examiner?	Hospital: 1 Inpat	ent 2 ER/Ou	utpatient 3E	DOA Oth	or.	dome 5 ☐ Resid		r (Specify)					
0 4	5 6	27. Manner of Death 1 ■ Natural 5 ■ Pend	28a. Date of Inj (Month, Da	ury 28b.	Time of	28c. Injur	y at k?	28d. Describe f	now injury occurre	ed .					
Division	To the Funeral Director: Affect completely filled in by the funeral Medical Certification:	2 ☐ Accident inves	d not be 28e. Place of In	jury - At home, fa tc. (Specify)	М		Yes 2 No	281. Location (S City or Tox	Street and Numbern, State)	er or Rural Route Number,					
Hospita	To the Funeral completely filled Medical Co		ing Physician: To the best at Examiner: On the basis of and manner s	of examinetion en											
Tom	Me Me	29b. Signature and title of certif		e number		29d. Date signed	(Month, Day, Year)								
1	1	Dr.	MAN	^	CIN	D	31464		11/13	3/00					
0	51/	30. Name and address of perso	n who completed cause of				3. () 1								
1) V	SHOALR A. 31. Date filed (Month, Day, Yes	HAS AMI	12111		on fr	finte	308 1	Balt. 1	MD 2120	1				
	State Registrar	Sate mos (month, bay, 168	LI 4 C 2002	fre seems	es p		and the	*							

ORIGINAL



State of Maryland / Department of Health and Mental Hygiene 0 36355

			Certi	ificate of	Death		Reg. No.	30300	,				
	1. Decedent's Nama (First, Middle, Last)	7350			2. Data of De Month	eath Day	3. Time of 0	Death				
Physician /Medical	Effie W. Jones-Br	eadman	Novemb			m.							
Examiner	4a Facility Nama (If not institution, giva	street and number)			4b. City, Town, o	r Location of Deat	h 4c. County	of Death					
	1300 Wilcox Stree	t			Baltim			/a					
Funeral Director	253-38-5044	7. Aga (In yrs	. last ontrody/	If Under 1 Yaar Months Days		8. Data of Bir (Month, Di Sept. 2	19,1923	9. Birthplace (Stata or Country), Georgia	r Foraigr				
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a Maryta tarf shor diffisit at ctor	Maryland N/A		altimore					1 🏹 Yas					
if with the Maryla 23e or 28e-f should ust be notified at ral Director	1300 Wilcox Street	t		10f. Zip Coda 212()2		United						
at, or items Examiner in by Fune	3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Evar in Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas:	tt Y	as Decedant of /as, specify Cut	oan, Maxicen, Pue	Specify Yas or Norto Rican, atc.)		e - America <i>n</i> Indian, ik, White, atc.					
TZ ho	15. Decedent's Edu (Specify only highast grad	cetion	16a. Decedar	nt's Usual Occu	pation	orkina	16b. Kind of Bu	sinass/Industry					
wd within 72 ho ygient. we then "naturn it, the Medical.] Completed	Elementary/Secondary (0-12)	Collega (1-4or 5+)		NOT use retire	during most of w	Orking	Restau	rant					
Mental Hyg rheed other stic event. To Be C	17. Fathar's Nama (First, Middla, Last)				18. Mothar's N Rennia	eme (First, Middle Strick)		a)					
2 sho	19a. Informant's Name/Relationship (7) Blanche Johnson/		19b. Mailing 1642 (Address (Stree Chilton	sand Number or I	Baltimore	per, City or Town, 2, MD 2:	State, Zip Coda) 1218					
mit. Pages 1 and partment of Health portant: if them 27 y injury or other 1 ICB.	20a. Method of Disposition 1 Burial 2 M Cramation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Nama of cematery, cramatory or other place) Chesapeake Crematory, Inc. 11/16/00 Beltsville, Market Crematory												
pemit. Pa Department Important: any injury ansi injury	21. Signature of Funaral Sarvice Licensea CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Drive Baltimore, 1												
	23a. Part1. Entar tha disaasa, or comp shock, or haart tailura. List only o	lications that caused the de						Approximate Interval Batw	9				
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The law requires that the death cerete has been signed by the attendir page 2 should be detached for use Completed by PhysicianA		on					s an autopsy ormed?	24b. Ware autopsy ti available prior to complation of ca of death?	0				
The law page 2						10	Yas 2 No	1 Yas 2	No				
ysicien: The I is certificate ha director, page To Be Corn	25. Was casa ratarred to medical				26. Place of D	eath (Check only							
Physicien: this certific ral director. TO Be	axaminar? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatiant 2	☐ ER/Outpatient	3 DOA O	thar: 4 Nursing	Home 5 Res	idence 8 Oth	ar (Specify)					
두 도등	1.	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju W	ury at ork?] Yas 2 ☐ No	28d. Dascribe	how injury occur	red					
To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 7	3 Suicide 6 Could not be datarmined	28a. Place of Injury - At building, atc. (Spec	homa, tarm, stree	et, tactory, office		28t. Location City or To	(Streat and Numb own, State)	per or Rural Routa Numi	ber,				
ne Hospital ne Funeral pletely filled edical C	29a. Cartifiar 1 Certifying Phy	stcian: To the best of my kr ner: On the basis of axamir and mannar stated.							:)				
within 2 to the comple	29b. Signatura and titla of certifier		DUF C	29c. Licar	se number		29d. Data signe	d (Month, Day, Year)	ST				
h	Dal Buch	bla MD RES OOG					November 15, 2000						
. ')	30. Name and address of person who co		em 23a) (Type, Pr					0.1					
~	Gail Berkenblit, M.D. 1000 F. Fager Street, Baltimore, MD 212												
State	31. Date tiled (Month Day Year)	32. Registrar's Sign	J. Loo	all									



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible 3 6 3 5 6 State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Das **Physician** CHARLENE AROWI 2000 6:45 PM November /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not Institution, give street end number) Examiner BALTIMORE JAT19204 CENTER If Under 1 Year | If Under 24 Hrs. Security 86-Age (In yrs, last birthday) 9. Birthplace (State or Fereign **Funeral** Days Hours 10 M 200F 869 Yrs. Director Usual Residence of Decedent with the Meryland 10a. State 10c. City, Town or Location 10d. Inside City Limits or Items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Be Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21225 d 12. Was Decedent Eyer in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1. Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: Baltimore, Maryland 21215-0020 1 Yes 21 No Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry then ondary (0-12) Cottege (1-4or 5+) d Hygie Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be 1 nent of Health and Mental Int: If Item 27 is marked or 19a. Informant's Name/Ralationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 le any Injury or other treu Place of Disposition (Name of Data 20b. 20e. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Foregral Service Liger Approximata Intervst Between Onset and Deeth four the disease, or complications that caused tha daeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, in haart fallure. List only one cause on each line. Physician Immediate Cause (Finel disease or condition rasulting in death) /Medical VACORDESPIBLIORY 1 MINUTE Examiner Due to (or as a consequence of) Physician/Medical Examiner HOROGRYP DRITZAW 24EARS Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events rasulting in death) Last Dua fo (or as a consequenca of) The law requires that the death certificate be execu 84EARS INFECTION P.O. Box 68760 Due to (or as a consequence of) 23h. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 ☐ Yas 2 ☐ No 3 Probably 4 □ Unknown IN DRUG USE Division of Vital Records, Be Completed by funeral director, page 2 ahould be 24b. Ware autopsy findings available prior to complation of ceuse of death? 24a. Was an autopsy performed? 2 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medicel 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 No Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred fnjury et Work? After 1 Matural 5 Panding Investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, atc. (Specify) 4 Homtcida 24 hours Hospital 1 Certifying Physician: To the best of my knowledge, daath occurred at the time, data and place, and dua to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred at the time, data and place, and dua to the cause(s) and manner stated. 29a. Certifier To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5000 HARBOR HOSPITAL CENTER CUILLER HO JOSE GIANGRECO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

NOV 1 6 2000

ORIGINAL

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** JOSEPH F. BROZIK NOV 16, 2000 1205 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FUTURE CARE CHESAPEAKE 305 COLLEGE PKWY ARNOLD. ANNE ARUNDEL If Under 1 Yea Montha Deys If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Deys 10M 20F Hours Director 216.03.5239 AUG 2, 1915 MD Usual Residence of Decedent 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Directo r 28a-f ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or ltams 23s or edical Examiner must be 528 NEWFIELD RD Funeral 21061 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 27 No if Yes, Give Year or Dates: Was Decedent of Hiapanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Meritel Stetus Black, White, atc. 1 ☐ Never Merried 2 ☑ Married Baitimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE by 3 Widowed 4 Divorced the Medical Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) ASSEMBLY LINE 10 GENERAL MOTORS 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Pages 1 and 2 should be fit ment of Health and Mental H tant: If Item 27 is marked off jury or other traumatic even Be JAMES BROZIK THERESA FLETER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) GLADYS BROZIK WIFE 528 NEWFIELD RD GLEN BURNIE, MD 21061 20a. Method of Disposition 20b. Plece of Disposition (Neme of cametery, cremetory or other pleca) 20c. Location - City or Town, State 1X Buriai 2 Cremetion 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) MEADOWRIDGE CEMETERY NOV18,2000 ELKRIDGE, MD GREGORY EAVE 27 YNR art of the RATE action P.A. 426 CRAIN HWY S. GLEN BURNIE, MD 21061 23a. Part. Enter the diverse or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, about, or heart failure. Let only one cause on each line. Approximete Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Preumonia Examiner Due to (or as a consequenca of) Examine nentio attending physician and for use as the burial-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequenca of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Was en autopsy performed? certificate has b 1 Yea 2 D No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) To Hospitai: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No Director: After thi 27. Manner of Death 1 Netural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation death. 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide HOURS The pritying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the Hor 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of continue D-50725 w 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rumpers Hole Rd. Severna Park MD 21146

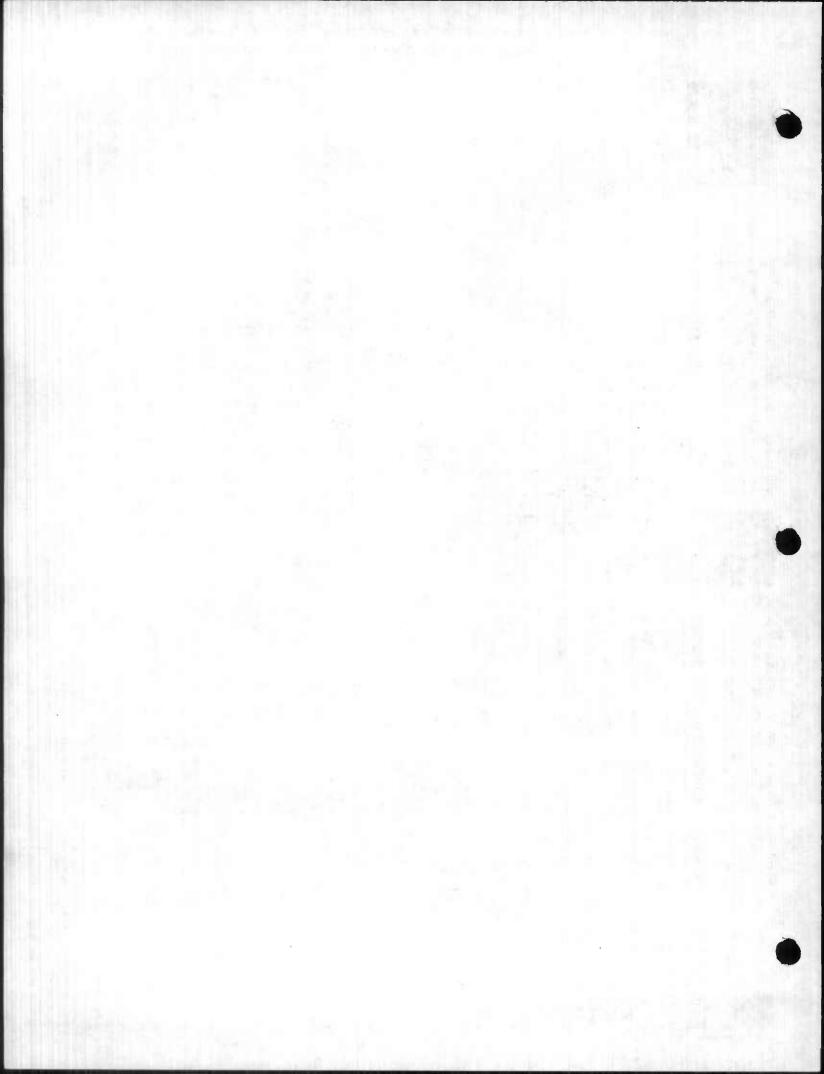
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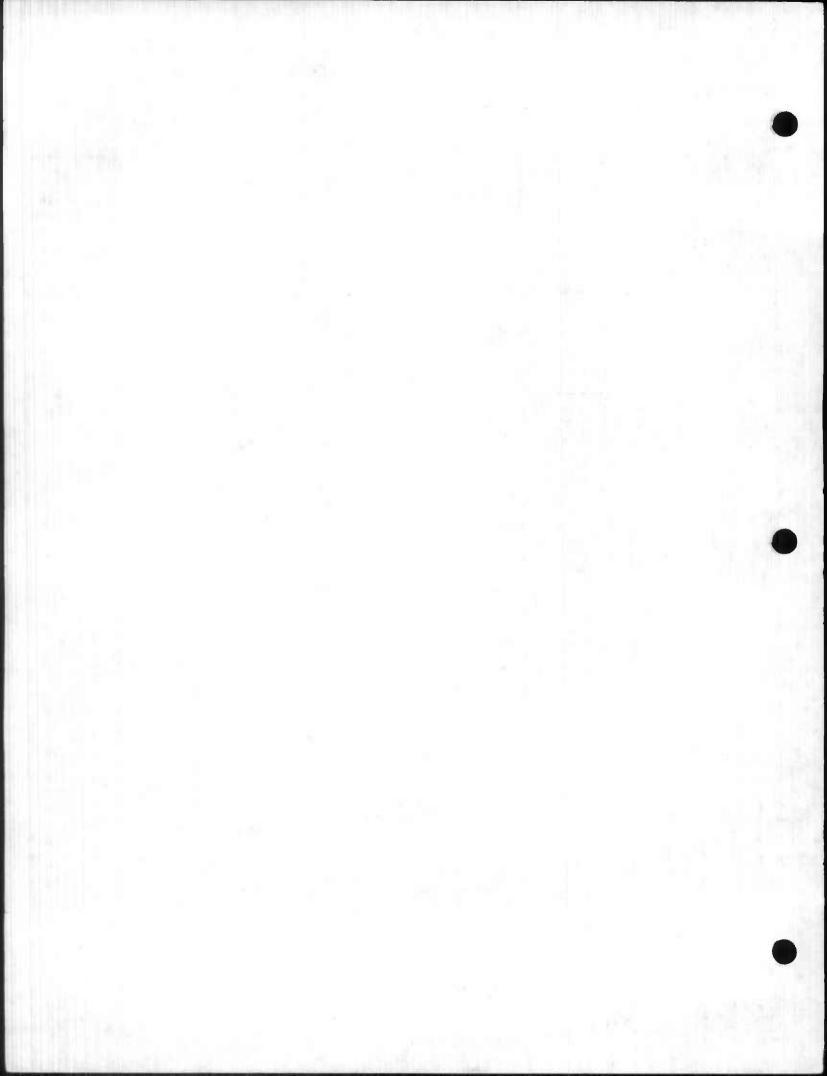
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Registrar's Signature



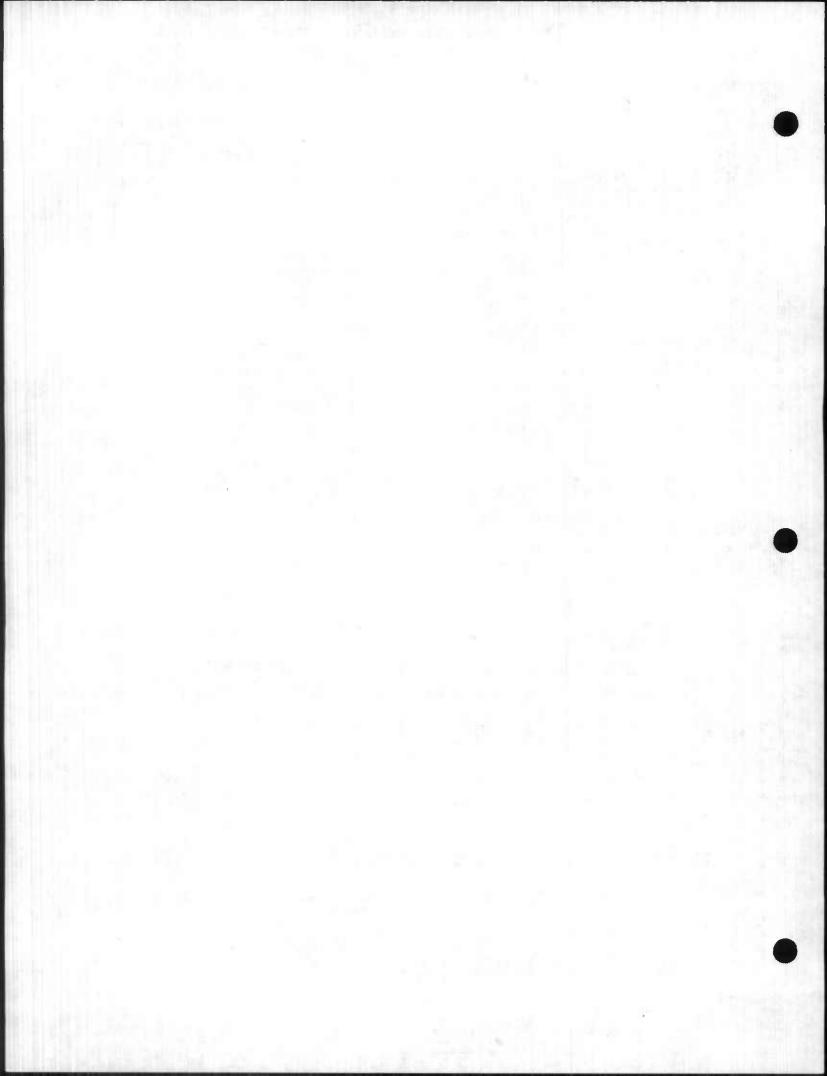
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	TY"JAE BROWN AMENDED ITEM #17 per f	State of Maryland / Department of Health and Mental Hygiene in G791 012401 SS Certificate of Death Reg. No.	00	36
nena	item 23a,27 per me G/91 1/23/01 yr	Certificate Of Death Reg. No.		
	Decedent's Name (First, Middle, Last)	2. Date of Death Month Day	Year	3. Time

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	Physician /Medical	TY'JA	E MAUR	ICE BR	OWN							12. 2000		0751 AM	
	Examiner	4a Facility Name (If n			ber)			4	b. City, To	wn, or Loca	ation of Death	4c. County	of Death		
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/la	Ment Ment	MAURICE	JOHNSON	- Brown					ROCI	HEL	BELTO	N			
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altimore	arte de la	21. Signature of Funeral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME													
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x 68760,	as the death certificate be executed by the attending physician and letached for use as the bunel-transit Physician/Medical Examin	Cause (Disease or Inj		c		ue to (or as e consequence of):									
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	N	30. Name and address	ARY G	completed ceuse	of death (Item	23a) (Type,	Print) n Str	eet,	Balt	imore	e, Mary	yland 21	201		
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Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 36359

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2 Accident 3 Suicide 4 Homicide City or Town, Stete) 29e. Certifier (Check only one) 29b. Signature and Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 29b. Signature and Miller 29b. Signature and Miller 29c. License number 29d. Date signed (Month, Dey, Year)			28a. Date of Injury (Month, Day Year) 28b. Time of Injury			Injury at Work?	28d.	. Describe how	v injury occurred			
29e. Certifier (Check only one) 29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print)	atic	1 41 41										
29e. Certifier (Check only one)		determined	288. Place of Injury - At nome, farm, street, factory, office									
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	9									Day Vaari		
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Francis Sanzaro, M.D. 13801 York_Rd., Cockeysville, MD 21030		30. Name and address of person who c	ompleted cause of death	(Item 23a) (Type	, Print)			,				
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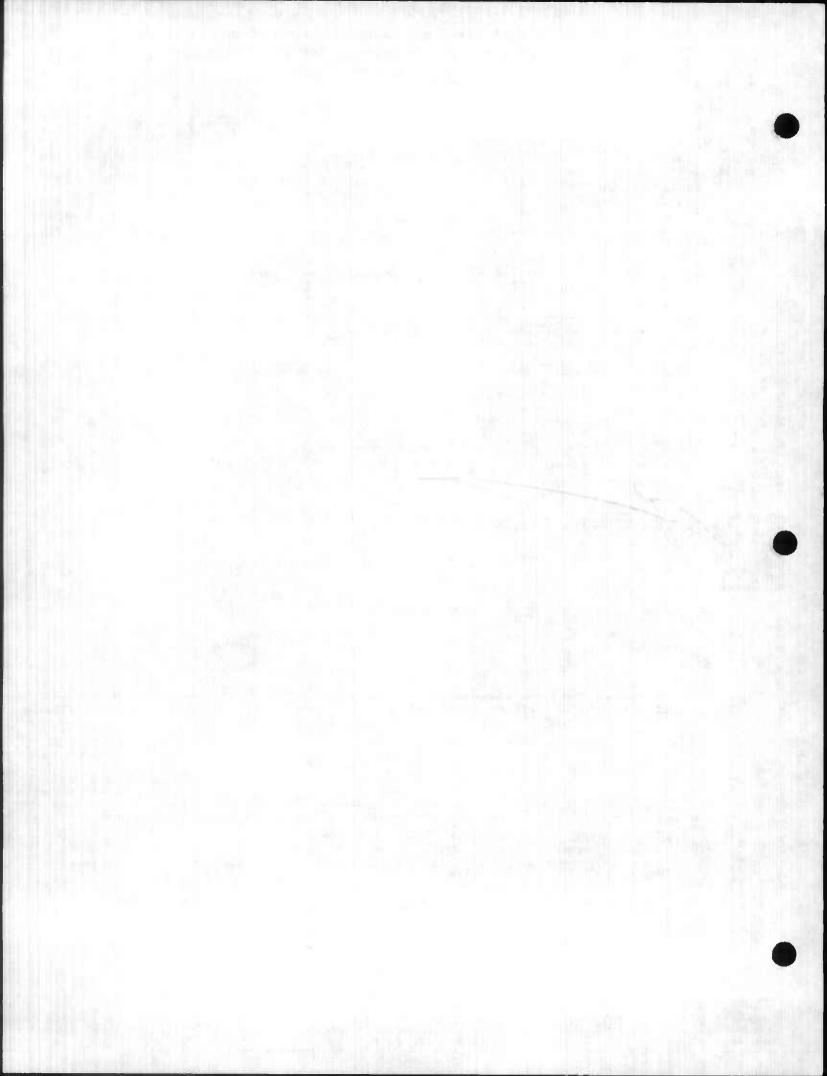


State of Maryland / Department of Health and Mental Hygiene []

	Certificate of Death Reg. No.											
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iner	4a Facility Nama (If not institution, give STELLA MARIS NURS					4b. City, Towr TIMON]		ocation of Death 4c. County of Death BALTIM			£	
	5. Social Security Number 6. Se 217–03–7026				ler 1 Year s Days	If Undar 24 Hours	Hrs. (B. Data of Birth (Month, Day 4/21/C	(, Year)	9. Birthplac	a (Stata or Forei	
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other traumatic event,	FRANK MULLER				ELLA HARTMA							
	19a. Informent's Neme/Ralationship (Type, Print) EDWARD BARTHOLOMAY SON				illing Addrass (Street and Numbar or Rural Route Number, OLD SPRING COURT COCKEYSV)							
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	1 X Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		GARDEN				11/	1/16/00 PARKVILLE, MD				
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A.											
	8521 LOCH RAVEN BLVD. TOWSON, MD 21286											
iner	Immediate Cause (Final disease or condition resulting in death) a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Dua to (or as a consequence of):											
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NAME: BARTHOLOMAY, LOUISA

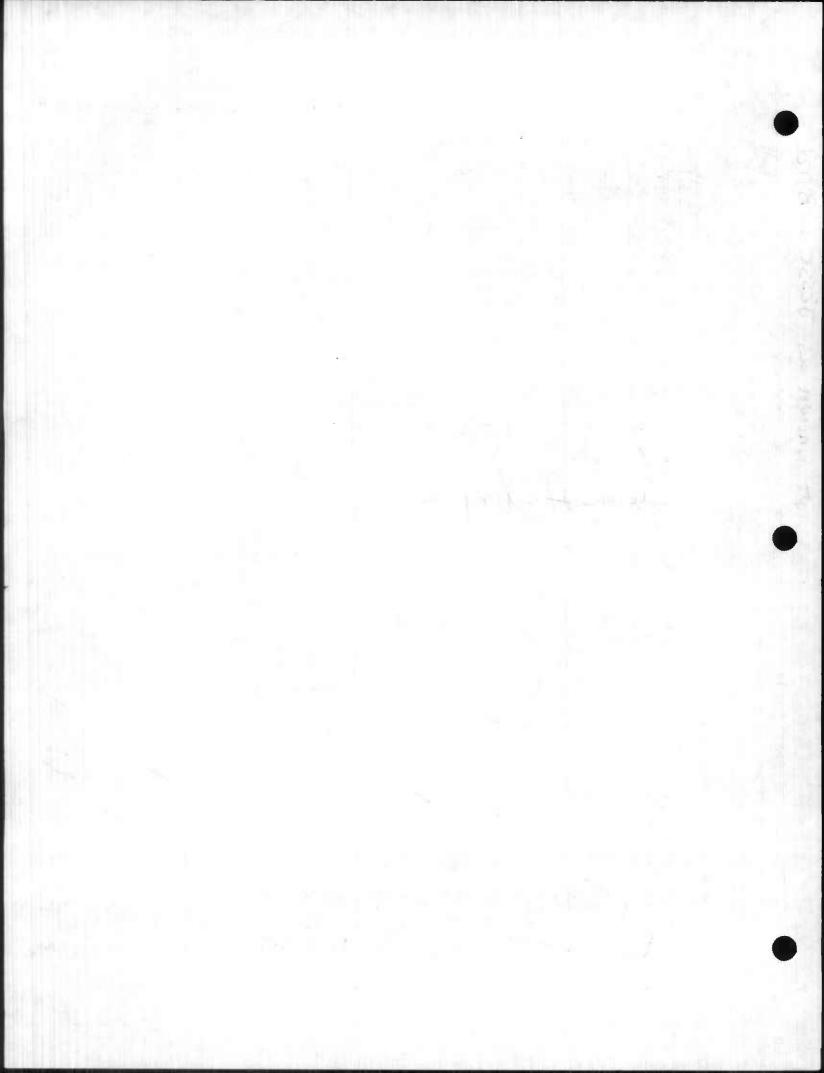


AMEND ITEM: 19A PER F.H. G789 11-25 tate of Maryland / Department of Health and Mental Hygiene AMEND ITEM: 9 PTR F.H. G789 11-21-00 WR. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 9:16 Am NOVEMBER 13, 2000 Byrd II Jesse /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner SINAI HOSPITAL OF BALTIMORE BALTIMORE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08 21 2 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) W.V. **Funeral** XXM 20 F Months Days Yrs. Director 233-22-7588 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Xes 2 No Baltimore Directo MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21209 4669 Falls Road 12. Was Decedent Ever in U,S. Armed Forces? t☐tYes 2 ☐ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 Yes 2 No Specify: þ 3√3 Vidowed 4 □ Divorced Black 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Oil Company 12th grade

17. Father's Name (First, Middle, Last) Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 88 Jesse L. Byrd Sr. Valaria Williams 19e. Intormant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21117 them 27. Marcella Goodall-Step-Daughter4600 Alcott Way, Unit 301, Owings Mill, Md Baltimore, 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State important: if its any injury or oth once 20a. Method of Disposition Date XIXBurlar 2 Cremation 3 Removal from State 4 Departion 5 Other (Specify) Md National Cemetery 11/17/00 Laurel, MD 21. Sonature of Funaral Service Light 22. Name and Address of Facility March F/H West PACh Enter the disease, or complications that caused the death. Do not ex, or heart failure. List only one cause on each line 21215 Androximete 4300 Wabash Ave, Baltimore Md Interval Between Onset and Death **Physician** Cause (Final condition in death) /Medical SQUAMOUS CELL LUNG CANCER Examiner Due to (or as e consequenca of) Examiner CHRONIC OBSTRUCTIVE PULMONARY DISFASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence ot) Box 68760. EMPYEMA WEEKS The law requires that the death certificate be Physician/Medical Due to (or as a consequence of): P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Wera sutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 Yes 2 DING of Vital 25. Was cose reterred to medical example? Physician: Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 17 Yes 2 No 28e. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28c. Injury et Work? After t Division 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident after dead 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) A 4 Homicide To the Hospital With 24 hours of To the Eucheral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and 29d. Date signed (Month, Day, Year) 29c. License number D0053495 NOVEMBER 13, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MD 2401 WEST BELVEDERE AVE KRAMER 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 6 ZUUU boardas

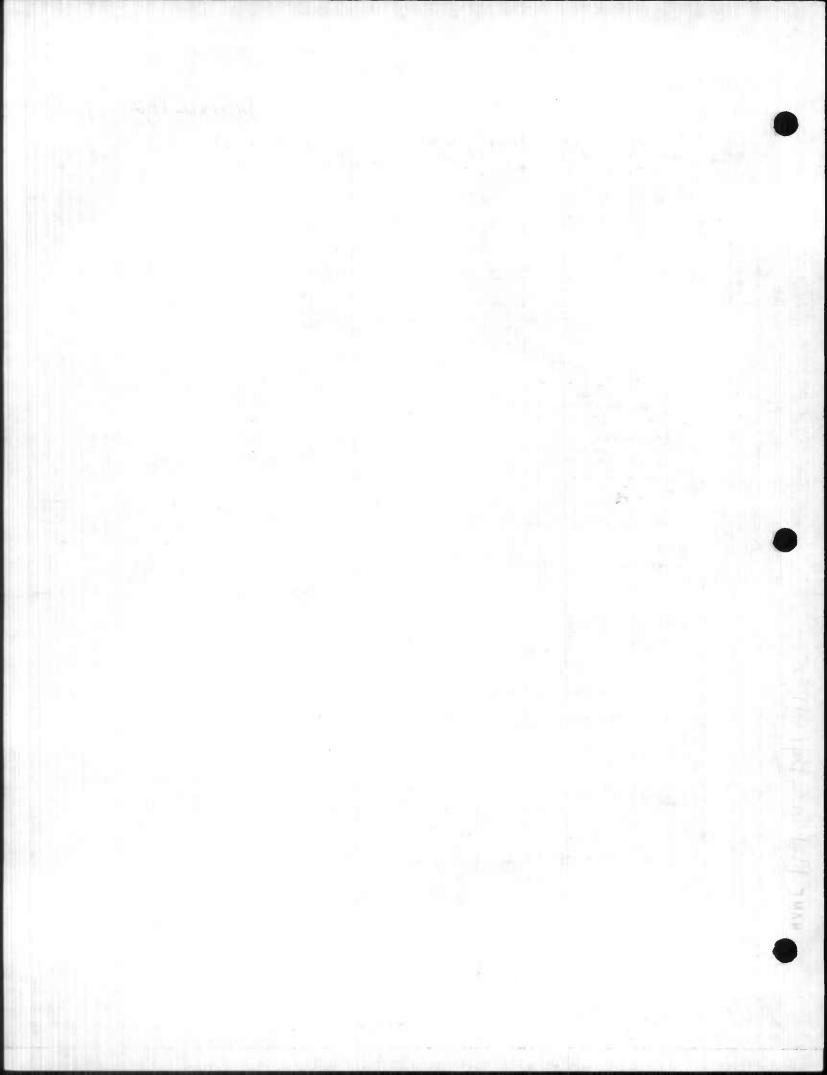
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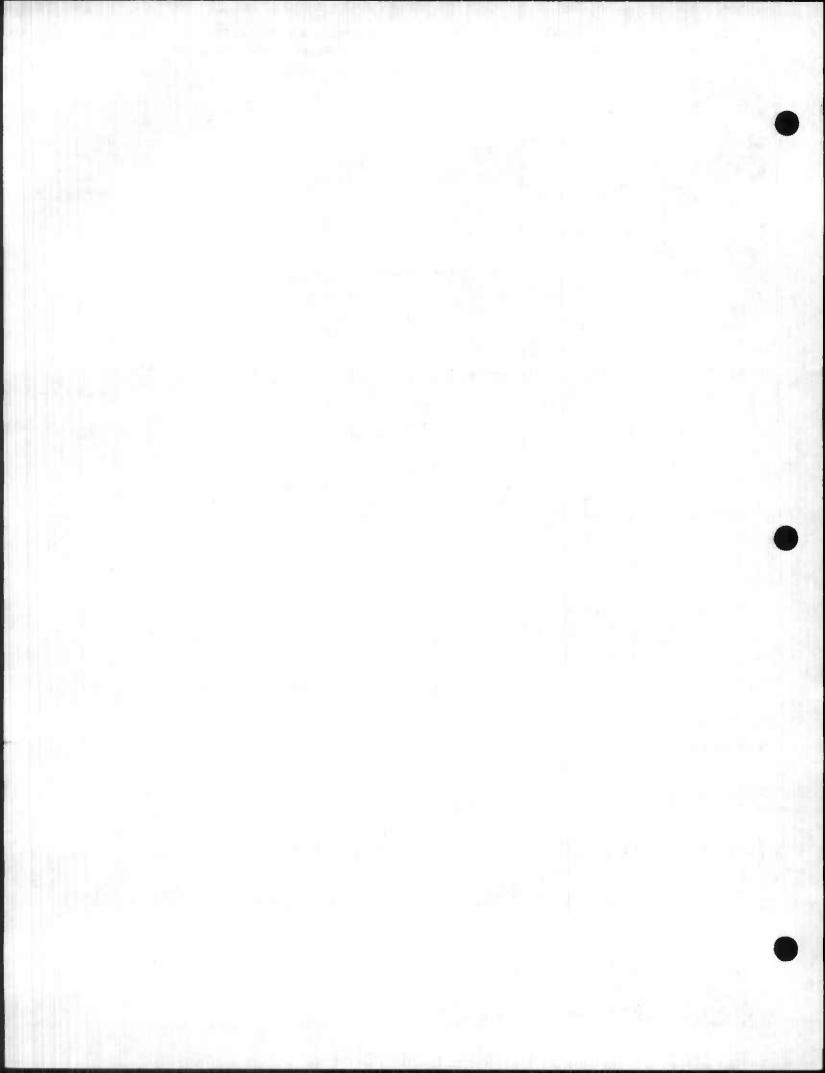
State of Maryland / Department of Health and Mental Hygiene 00 36362

	Certificate of Death	Reg. No.	00 00002
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	Usual Residence of Decedent		- 110
ith the Merylan or 28s-f ehow	10a. State 10b. County 10c. City, Town or Location Baltimore		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
after death with the Meryla or frame 28s or 28s-f shor	MD N/A Baltimore 10e. Street and Number 10f. Zip Code 2819 Florida Ave. 21227	10g. Citiz U • S	en of What Country?
5-0020 72 hours after death with the Manyland natural, or thems 23a or 28a-f show ace I servine must be notified a	2019 F1011da Ave. 2122/ 11. Marital Status 1 Never Married 12 Never Married 12 Never Married 12 Never Married 12 Never Married 13 Never Married 14 Never Married 15 Never Married 16 Never Married 16 Never Married 16 Never Married 17 Never Married 16 Never Married 16 Never Married 16 Never Married 17 Never Married 18 Never Married 19 Never Married 10 Never Married		4. Race - American Indian, Black, White, etc. Specify: White
15-00%	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Painter 17. Father's Name (First, Middle, Last) 18. Mother's Name 19. Mamin of the completed of the completed of the complete of th	king 16b. Kin	d of Business/Industry
within one.	Elementary/Secondary (0-12) College (1-4or 5+) Respondence of the college (1-4or 5+) Respondence of the college (1-4or 5+)		
D BELLE	8 Painter 17. Father's Name (First, Middle, Last) 18. Mother's Nem	ne (First, Middle, Meiden S	rucking Sumame)
land be sental	Cletus George Byrum Mamie	A. Stansbury	у
Mary and 2 shot 27 is mary	19a. Informant's Name/Relationship (Type, Print) Shirley Byrum, wife 19b. Mailing Address (Street and Number or Ru		
Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filled within 72 hours alt Department of Heelth and Mental Hygiene. Important: If them 27 is marked other than "natural", or any Injury or other traumatic event, the Marcal Farmands.	20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of carmetery, crematory or other place) Glen Haven Memorial Park		Glen Burnie, MD
Ball Pemil: Depending any la	21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Ambrose Funeral Ho 2719 Hammonds Ferr		
Physician /Medical	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiretory arrest,	Approximate Intervel Between Onset and Death
Examiner	disease or condition a. Ary Marka Due to (or as a consequence of):		30 mm
7 4			30 640-
E 00 5	Cause (Disease or injury that initiated events		
O company	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did tobacco u	usa contribute to the cause of death?
. 6 80	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Hypertension, Elingth Chalister	1 Yea 20	No 3 Probably 4 Unknown
aw require		24a. Wes en eutops performed?	24b. Were eutopsy findings evailable prior to completion of cause of death?
		1 □ Yes 🐔	No 1 □ Yes 2 □ No
VITA	25. Was case referred to medical axaminer?	eth (Check only one)	
Division of Vital Bive Attending Physician: T sine death. In Director, After the certificate of in by the tuneral director, p.	1 Yes 229-No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing H	lome 5 ☐ Residence 6 28d. Describe how injury 28f. Location (Street and	
- / V		City or Town, State)	
NAME 	(Check only ane) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occur and manner stated.		
2 4128	29b. Signature and title of eacifier 29c. License number	29d. Date	signed (Month, Day, Year)
170	160)- William 16 B67848998	Nove	mbr 14, 2000
21.0	30. Name and address of person who completed cause of death (Hern 23a) (Type, Print) St. Agnet 17. Robert Greenhald MD 900 CATON August Ballmark	tospital	21229
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature		



State of Maryland / Department of Health and Mental Hygiene 36363

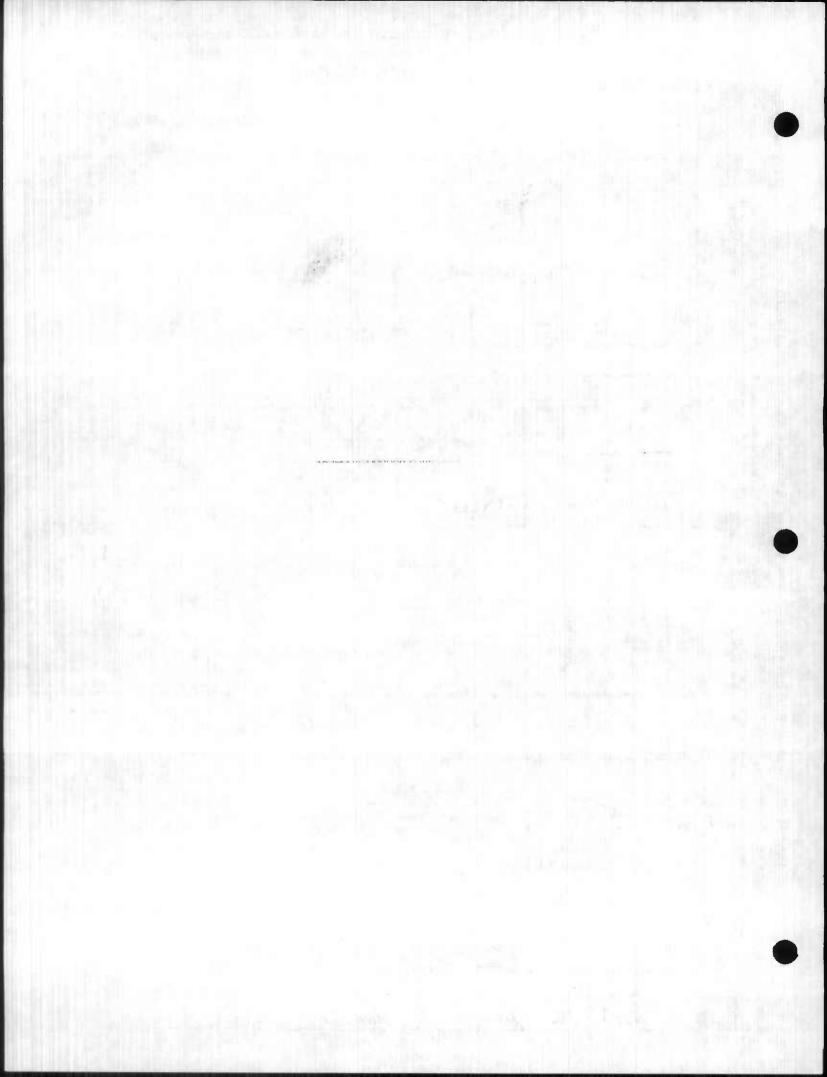
			C	ertificate	of Death		Reg. No.		
	1. Decedent's Name (First, Middle, Las	st)				2. Date of	Death	Vana	3. Time of Death
Physician (Madical	James Donald Blades	3				Novem	per 10	2000	09:25 A.
/Medical Examiner	4a Facility Name (If not institution, give				4b. City, To	wn, or Location of De	eath 4c. County		
Examino	8025	Bradshaw R	oad		Kii	ngsville	Ra	ltimo	ra
Funeral	5. Sociel Security Number 6. Se	ex 7. Age (/	n yrs. lest birthd	ay) If Under 1 Y	eer If Under	24 Hrs. 8. Date of	Birth	9. Birthp	lece (State or Fore
Director	076 16 9124 3	PM 20F 83	Yrs	Months D	ays Hours	Min. Merch	10 1917	Lang	Ísland
B 10	10a. State 10b. County	10	Dc. City, Town or	r Location	1.00			1	0d. Inside City Lin
4 0	Maryland Baltimore		Kingsvil	le					1 ☐ Yes 2 ☐
or 28er	10e. Street and Number			10f. Zip Co	de		10g. Citizen of	What Coun	trv?
	8025 Bradshaw Road			2108	5		USA		
af, or itsms 23 Examiner must by Funeral	11. Marital Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: W		3. Wes Decedent If Yes, specify 1 ☐ Yes 2 ☒		gin? (Specify Yes or , Puerto Rican, etc.)	No- 14. Rad Bla Specif	ce - Americ ck, White, o	etc.
ypiens. we than 'natur it the Medical Completed	15. Decedent's Ed (Specify only highest gra-	lucation de completed)	(G	ecedent's Usuel O	one during mos	of working	16b. Kind of B	usiness/Inc	lustry
A SA DE	Elementary/Secondary (0-12)	Cotlege (1-4or 5+)		e. DO NOT use n	stired)		Colf Do	1	
Co Co		I/A	Carp	enter			Self Emp	-	
T 8 8	17. Father's Name (First, Middle, Last)					r's Name (First, Mid	die, Maiden Suman	ne)	
Menta arked aftic en To E	James Donald Blades				Jerni	e Clark			
DEE	19a. Informant's Name/Relationship (7					er or Rural Route Nu			Code)
122	Michael L Blades (Son)		114	Audrey Av	enue Bal	timore, Mary	land 21225		
A Family Company	20a. Method of Disposition		20b. Ptace of Di	sposition (Name or	place)	Date	20c. Location	- City or To	wn, State
At: III	1 Burial 2 Tremation 3 4 Donation 5 Other (Specify			ematory In		r 18 2000	Baltimo	mo Mm	arland
144	21. Signature of Funeral Service Licen		TELLO CL	22. Name and A			Darchin	re, re	Lylaiu
9 6 6 8	24			FF Lassah	n Funeral	Home PA			
0200	COHO TER	ch Chon	3cti			Kingsville,	Maryland 2	1087	
	23a. Pert1. Enter the disease, or comp shock, or heart faiture. List only	olicetions that caused the	e deeth. Do not	enter the mode of	dying, such as	cerdiec or respirator	y errest,		Approximate Intervat Between
m and fial-transit Examiner	resulting In death)	a. Contac							
physician and s the burial-transit edical Examir	Sequentially list conditions, if any, teeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events	С	e to (or as a con	sequence or):					
Me as	resulting in death) Last	d.	e to (or as a con	sequence of):				1	
e atten	Part II. Other eignificant conditions of	ontributing to death but n	ot resulting in th	e underlying caus	e given in Pert I	. 23b. [oid tobacco uee co	ontributa to	the cause of de
1 by the etache							□ Yes 2,2(No	3 Prol	bebly 4 Unk
2 should						P	Vas an autopsy enformed?	av	ere autopsy findin allable prior to mpletion of cause death?
page Com						1	ØYes 2□No	1,	Yes 2 No
certificata rector, pag	25. Was cese referred to medical				26. Place	of Deeth (Check or	nly one)		
nis certific Il director, To Be	examiner? 1 XYes 2 No	Hospital: 1 ☐ Inpatient	2 ☐ FR/Outpe	itient 3 DOA	Othor:	rsing Home 5 R		her (Specif	(v)
2 = 1	27. Menner of Deeth	28a. Date of Injury	28b. Tim	e of 28c.	Injury at Work?		he how Injury occu	rrad	
h. After th funeral	1 Natural 5 Pending investigation	Found Y	ear) Inju	in of M	Work? 1 ☐ Yes 2,⊠	No Subj	ect Sho	+ sei	15
after death. I Director: After to a line by the funeral Certification:	3 Suicide 6 ☐ Could not be	11-10-26	00 08	00		28L Locatio	n (Street and Num	ber or Rure	I Route Number.
after death. Director: After d in by the funer.	4 Homicide determined	28e. Ptace of Injury building, etc. (5 8			City or	Town, State) 80	25 6	radshan
S Tell			esiden				nose Coun	7	anyland
within 24 hours after deat To the Funerel Director: completely filled in by the Medical Certifical		ysician: To the best of m niner: On the basis of ex and manner steted	amination and/o						
within To the comple	29b. Signature and title of certifier		13000	29c. L	cense number		29d. Date signe	ed (Month,	Day, Year)
1	11.	A ul	1/-	44 0	0.0 M	T.	2.		11 000
1/	Jugsh,	m via	dy	MID	O.C.M.	E.	Nove	mber	11, 2000
11	30. Nama and address of person who o				ot Del	+ima			
NV	Stephen S. R	-adentz,	TITE	em stre	er, Bal	timore, M	aryland 2	21201	
State	31. Date filed (Month, Day, Year)	A2 Registrace	Signature	Spark	1				
Registrar	MAN T A TOOR			//	5 p				



State of Maryland / Department of Health and Mental Hygiene

00 36361

		AN	MEND#20A&B PER F.H. G789	911-16-2000 JAB	Ce	ertificate	e of E	Death	R	eg. No.	U ,	30364
			1. Decedent's Name (First, Middle, Last			39-			2. Date of Dear Month	th Dey	Year	3. Time of Death
	Physicia /Medic	_	Gasper Botteon Jr						November		1 6-01	8:55 am
	Examin		4a Facility Neme (ff not institution, give	street and number)			48	o. City, Town, or L	ocation of Deeth	4c. County	of Death	
		1	Genesis Eldercare Pen	ring Parkway				NA		Baltim	orre	
	Funeral		Social Security Number 6. Se	TM ADE		/) If Under Months	1 Yeer Deys	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Dey	Year)	9. Birthp	place (Stete or Foreign ntry)
	Director		218 22 /8/1	73	Yrs.				February		Balti	more, Maryland
	¥		Usual Residence of Decedent 10a. Stete 10b. County	10c. Ci	ty, Town or I	Location						10d. Inside City Limits
	laryta at at	5	Maryland N/A		imore							1 ☐ Yes 2 ☐ No
	The Y	Directo	10e. Street and Number	Dati	THOLE	10f. Zip	Code		1	Og. Citizen of	What Cou	ntry?
	n with the Mary tas or 28s-f sh at be notified.	0.000										
	the 23	Funeral	1513 Elringo Street 11. Mentel Stetus	12. Wes Decedent Ever in L	l.S. 13	2122 Wes Deced		spanic Origin? (Sp	ecify Yes or No-	USA 14. Rad	ca - Americ	can indian,
_	har d	F	1 Never Merried 2 Married	Armed Forces? 1 △Yes 2 No		If Yes, spec	cify Cubar	n, Mexican, Puerto	Rican, etc.)	Bla	ck, White,	, etc.
020	P. O.	by	3 ☐ Widowed 4XXDivorced	If Yes, Give Year or Dates: W I]	1 ☐ Yes	2⊠ No	Specify:		Specif	y:	White
Maryland 21215-0020	72 hor	pet	15. Decedent's Edu		16a. Dec	edent's Usua	ai Occupe	tion		16b. Kind of B		
21	S SW	Completed	(Specify only highest grad	College (1-4or 5+)	life.	DO NOT us	se retired)	uring most of work	mg	0.36 -		
2	of the second	No.	12	NA	Builde	er				Self Em	ployed	
Pu	を見る	e e	17. Father's Name (First, Middle, Last)					18. Mother's Nam	e (First, Middle, I	Maiden Sumar	ne)	
yla	Ment Went whee	2	Gasper Botteon Sr					Martha Dia	nna			
lar	State of the state		19a. Informant's Name/Relationship (T)	rpe, Print)				nd Number or Rui				p Code)
	and eath n 27		Debrah A Style	Total Control of the				load Abing	-			
timore	A COLUMN		20e. Method of Disposition 2 Cremation 3 DF	Removal from State	Piece of Disp cemetery of MFJRO	position (Nem	ne or ther place RV- TN	2)		20c. Location	- City or To	own, State
E	Pages ment of sent: If it jury or o		4 □ Donetion 5 □ Other (Specify)		HEIROR	Natio	al C	iii. Nov. 15	2000 I	Baltimore	Mary.	land
Sal	appart in part		21. Signature of Funeral Service Licens	ee ·	Ī	22. Neme an	Address	s of Facility al Home In				
-	20240		Mather Massal	m Chorack	17	7401 Bel	lair R	oad Baltim	ore. Marvi	and 2123	6	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only o	ications thet caused the dee ne cause on each line.	th. Do not e	nter the mod	le of dying	, such es cardiec	or respiratory arr	est,	1	Approximate Interval Between
	Physician			\cap							- 1	Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in deeth)	Pn	Rum	mig					1	1 Man 14
н		_	resulting in openin	Due to (or es e cons	equenqe ov:						1 ()
	ped isit	Examine		- Hdvan	Ced	To	36 K	in Soms.			i	1 year.
	death certificate be executed estending physician and and for use as the burial-transit	xar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or es e cons	equenca of):					i	0
68760,	siciar buri	a	Cause (Disease or injury that initiated events	C							1	
68	ufficate ng phy as the	edical	resulting in death) Last	Due to (or es a conse	equenca or):						
Вох	attending for use	M		d			_					
0	death e atte	Ca	Pert II. Other significant conditions co	ntributing to death but not re	sulting in the	undertving c	ause give	on in Pert I.	23b. Dld to	obacco use co	ontribute 1	to the cause of death?
P.0	ch the	Physician/							101	08 2 No	3 Pro	obably 4 Unknown
	es that igned b	by F									1	
Records,	been sign should be								24a. Wes e	en autopsy med?	81	Vere autopsy findings vailable prior to
900	2 s S	ple									of	ompletion of cause f death?
æ	0 - 0	Completed							1 🗆 Y	es 21 No	1	☐ Yes 2☐ No
Vital	Iclan: The certificate rector, pay	Bec	25. Was case referred to medical					26. Plece of Dee	th (Check only or	ne)		
>	G 10 2	10	examiner?	Hospital: 1 ☐ inpatient 2 ☐	ER/Outpeti	ent 3 DC	OA Othe	er: 4 Nursing H	ome 5 Resid	ence 6 □Ot	her (Spec	eify)
n of			27. Manner of Death 1 ☐ Naturel 5 ☐ Pending	28a. Date of injury (Month, Dey Year)	28b. Time Injury	of 2	28c. Injury Work	et ?	28d. Describe h	ow injury occu	rred	
0	Attending or death. ector: After by the fune	atle	2 Accident investigation			М	101	res 2□No				
Division	- 2	Certification:	3 ☐ Sulcide 6 ☐ Could not be determined	28e. Placa of Injury - At h building, etc. (Speci	iome, ferm, s	street, fector	y, offica		28f. Location (S City or Tow		ber or Rur	rel Route Number,
0	ra sal											
	Mospital of the Mospital of the Mospital Distriction of th	edical	(Check only 2 Medicai Exami	sician: To the best of my knoner: On the basis of examination	owledge, dea ation and/or	ath occurred investigation	at the tim , in my op	e, date and place, pinion, death occur	and due to the or red at the time, or	ause(s) and m late and place	anner as	stated to the cause(s)
	To the	Med	one) 29b. Signature and title of eestifier	snd/manner stete		296	c. License	number		29d. Date sign	ed (Month	Dav. Year)
	FEER		1/6/	/ //		-	100	4547	_	41-	15	3-700
	Ny V		1-010	re C	- 00-1 (T	- Delecti	1	13/1				200
1	5/1		30. Name and address of person who o	ompleted cause of deeth (Ite	m 238) (Typ	e, rint)						
	Sta	to	31. Date filed (Month, Day, Year)	32 Registrar's Sign	eture 🎍	-						
	Sta Registr		NOV 1 6 2000	Denevas	9.	Ana	· Kal	/				



Please Type or Print in Black Indelible Ink. Assure Ali Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 2. Data of Death Month izabe H 11/13/2000

If Undar 1 Yaer

10f. Zio Code

1 Yes 2 No

21084

16a. Decedant's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT usa retired)

22. Nama and Addrass of Facility

E.F.Lassahn Funeral Home

Days

Months

7. Aga (In yrs. last birthday)

82

12. Was Decedant Evar in U,S.
Armed Forces?
1 Yas 2 Yo
If Yas, Giva

Year or Dates:

College (1-4or 5+)

Yrs

Jarrettsville

Housewife

20b. Place of Disposition (Nama of cemetary, cramatory or other place)

Cardiomyopa

Diabete

Renal

Due to (or es e consequence of)

Gardens of Faith Cemetery

10c. City, Town or Location

4b. City, Town, or Location of Death

Jarrettsville

Hours

13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.)

Physician /Medical Examiner **Funeral**

Director

4a Facility Neme (If not institution, give street and number)

1□ M 2□ F

Road

1316 Baldwin Mill Road

10b. County

Harford

213-05-6081 Usual Residence of Decedant

10a. State

Director ð 238 Pages 1 and 2 should nt of Health and M. If Itam 27 is man

izabeth 18

Physician /Medical Examiner

page 2 To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A filled in by

Medical

The law requires that the death certificate be axecuted

or Attending Physician:

Division

of Vital Records, P.O. Box 68760,

10e Street and Number 1316 Baldwin Mill Funeral 11 Marital Status 1 Nevar Married 2 Married 3 ₩idowed 4 Divorced Examine Physician/Medicai Be Completed by Certification: To 1. Neturat 2 Accident 3 Suicide 4 Homicide

15. Decedent's Education (Specify only highast grada completed) Elementary/Secondery (0-12) 8 years George Lein 20a. Method of Disposition Immediata Cause (Finat diseasa or condition rasulting in death) Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disease or injury that initiated avants resulting in death) Last 1 Yas 2 No 27. Manner of Death

17. Father's Nama (First, Middle, Last) 19a, Informant's Name/Relationship (Type, Print) Helen Bethke (daughter-in-law) 1X Burial 2 Cramation 3 Removal from Stata 4 Donetion 5 Other (Specify) 21. Signeture of Funeral Service Licensee assal 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one cause on each line. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 25. Wes case referred to medical axaminar?

Hospitat: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of tnjury (Month, Day Year) 28b. Tima of 5 Panding invastigation 6 Could not be detarmined

 Plece of Injury - At home, farm, street, factory, office building, atc. (Specify) Telegraphysician: To the best of my knowledge, death occurred at the time, deta end place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the best of examination and/or invastigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated.

29c. Licensa number

28c. Injury at Work?

2 No

29d. Data signed (Month, Day, Year) -13-2000

Location (Street and Number or Rural Routa Number, City or Town, Stata)

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No

2 200

24e. Wes an autopsy performed?

1 Yas

28d. Dascribe how injury occurred

Other: 4 ☐ Nursing Homa 5 🗷 Rasidance 6 ☐ Other (Specify)

26. Placa of Deeth (Check only one)

3. Time of Death

8:30AM

10d. Inside City Limits 1 Yas 2 No

Approximata Interval Batween Onset and Death

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of causa of death?

1 Yes 2 No

10 years

9. Birthplace (State or Foreign Country)
Balto., MD

4c. County of Death

10g. Citizen of What Country?

16b. Kind of Business/Industry

20c. Location - City or Town, State

her own home

11/15/2000 Baltimore County,

14. Race - American Indian, Black, White, etc.

white

USA

Harford

8. Date of Birth (Month, Day, Year) 4/3/1918

18. Mother's Name (First, Middle, Maidan Sumama)

Frances Hirsch

19b. Mailing Address (Straet and Number or Rural Routa Number, City or Town, State, Zip Code) 1322 Baldwin Mill Rd Jarrettsville, MD 21084

11750 Belair Rd Kingsville, Md 21087

30. Nama and addrass of person who completed cause of death (Itam 23a) (Type, Print)

39 Churchville Rd. Suite 200 BelAir, Maryland 31. Dete fited (Month, Day, Year) 32. Registrar's Signature

NOV 1 6 2000

29b. Signature and titla of certifier

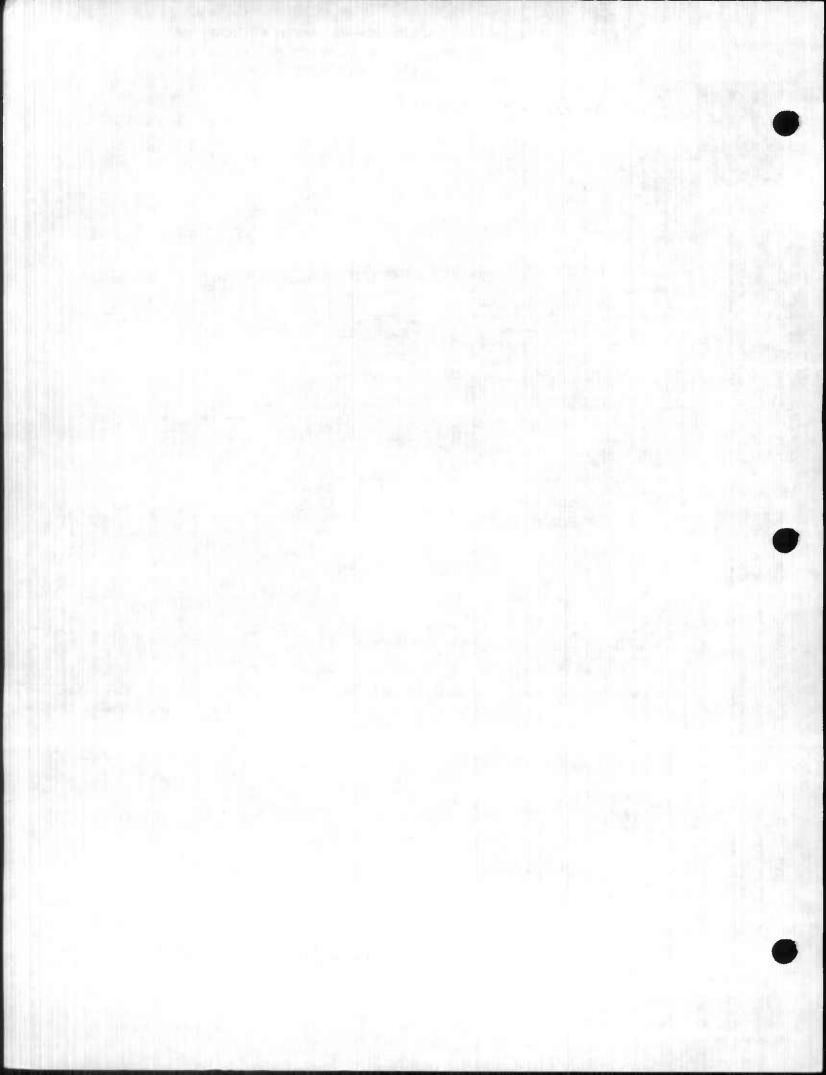
DAAA

(Check only one)

mn

DHMH 16 Ray 6/95

Registrar



Please Type or Print in Black indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36366 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** BOWEN MARY :40 pm 2000 NOVEMBER 11 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Deeth Examiner BALTIMORE MEDICAL CONTOL. HOPKINS BAYVIEW If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Yeer 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days 10 M 2 F 226-07-1803 83 Director May 21,1917 Va. Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yas 2 XNo Director Baltimore Dundalk r than "natural", or flams 23a or 28a-f the Medical Examiner must be notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3434 Cornwall Rd 21222 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Tyes 2 No Specify Specify: White by 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygians. Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Catering Co. 12 yrs. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Pages 1 and 2 should be till mant of Health and Mental H ant: If them 27 is marked off Nathaniel Lawson Jones Ida Sandridge and w 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Lucille Stephenson Sister 3663 Browns Gap Turnpike, Crozet, Va. Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete Nov 14 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Cemetery 2000 Elkridge, Md. 21. Signature of Funeral Service License, 22. Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Rd. Dundalk, Md.21222 23a. Renti: Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each line. Approximete tnterval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical MYOCARDIAL INFARCTION Examiner Due to (or es e consequence of): Examine attending physician and for use as the burial-transit death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760 Physician/Medical Due to (or as a consequence of) bethe 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Records, P.O. 1 Yes 2 No 3 Probably I Unknown 3 signed by The law requires that FIBRILLATION þ 24b. Were autopsy findings available prior to completion of cause of death? been signal 24a. Wes en autopsy Completed STROKE P. 20 ils certificata ha 1 Yas 2 No 1 TYes Division of Vitai or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 tnpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this After this 27. Menner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Netural 2 Accident Injury deeth. 1 Yes 2 No Director: / 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 6 ☐ Could not be 28e. Plece of injury - At home, farm, street, factory, office building, etc. (Specify) after 4 Homicide To the Hospital o Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and dua to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the ceuse(s) and manner stated. edicai 29e. Certifier 29b. Signeture end title of certifie 29c. License number 29d. Date signed (Month, Day, Year) NOVEMBER 12, 2000 30. Neme and address of person completed ceuse of deeth (Item 23a) (Type, Print) NED CAR. 4940 GASTERN AVE. JUMED JOANS HOPKIN VIEW MURTUZA 4

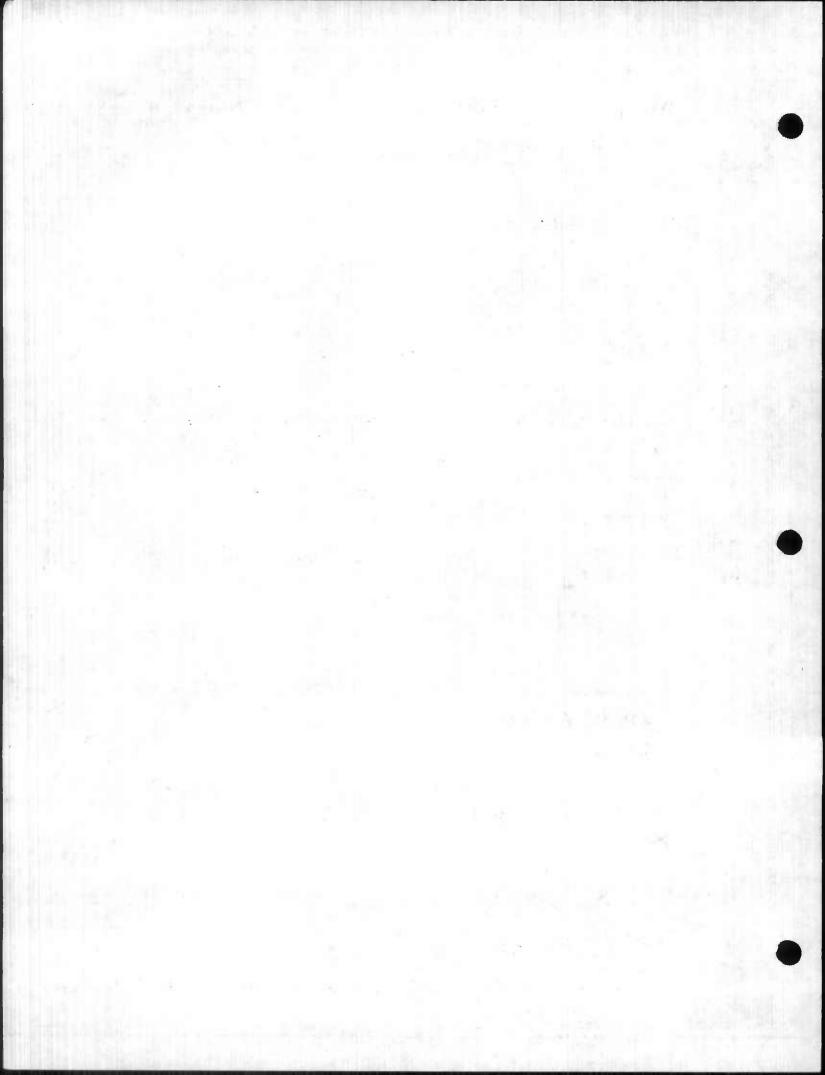
State

Registrar

31, Date filed (Month, Dey, Year) 32, NOV 1 6 2000

32. Registrar's Signeture

A Apollo



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death Year Month Day Michael Stephen Barrett November 15, 2000 6:30 AM 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth 10910 Olde Woods Way Columbia Howard If Under 24 Hrs. Hours Min. If Under 1 Year Months Deys 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 1 M 2□ F Months 48 002-42-0208 Dec. 26.1951 New Hampshire Usual Residence of Deceden 10d. Inside City Limits 10a. Stata 10b. County 10c. City, Town or Location 1 Yes 2 No Maryland Columbia Howard 10f. Zip Coda 10g. Citizen of What Country? 10e. Street and Number U.S.A. 10910 Olde Woods Way 21044 12. Wes Decedent Ever in U,S. Armed Forcas? 1 Yes 2 No If Yes, Give Yeer or Detes: Rece - American Indian, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Stetus 1 X Never Married 2 Merried 1 ☐ Yas 2 ☒ No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade com 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) 12 Roman Catholic Priest 5+ 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) S. Michael D. Barrett Mary McLaughlin 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Rev. Ronlad D. Witherup, S.S. 5408 Roland Avenue Baltimore, Maryland 21210 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Blossom Hill@Cemetery 11/20/00 Concord, N.H. 21. Signeture of Funerel Service Licenses 22. Name end Address of Fecility Baltimore, Maryland 2 Inc. 5305 Harford Rd. Halsoch Leonard J. Ruck, Inc. 23a. Pert1. Enter the disease, or complications that cause of the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart fellure. List only one cause on each a. Intervel Between Onset and Death Immediate Cause (Finel diseasa or condition resulting in deeth) Immunodeficience ACQUIRED drome Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or Injury Due to (or es e consequence of) that initieted events resulting in death) Lest Due to (or es a consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown achexia 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Meturel 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 T Homleide

tha deeth certificate be executed been signed by the attending physician and should be detached for use es the bunal-transit Box 68760 P.O. requires that Division of Vital Records. The law After this certificate has page To the Hospital or Attending Physician: within,24 hours after death.

Active Funeral Director: After this certific dempletely filled in by the funeral director, Attending

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

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the Maryland

d 2 should be filed within 72 hours after death with the Marylar Ih and Mental Ihyjiene.
7 le marked other then "natural", or fleme 23s or 28s-f show traumatic event, its Medical Establishments hours of

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oths any Injury or other traumatic event, phose.

Physician

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Physician/Medical Examiner

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Completed

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Saltimore, Maryland 21215-0036

Certification: Medical Registrar

DHMH 16 Rav 6/95

31. Dete filed (Month, Day, Year) State NOV 1 6 2000

29e Certifier

29b. Signature and title of certifier

Daliah K. Salahuddin, M.D.

30. Name end address of person who completed cause of desth (Item 23a) (Type, Print)

Salah Salahuddu

32. Registrer's Signeture Denavas

1940 W. Baltimore Street

12 Certifying Physician: To the best of my knowledge, deeth occurred at the tima, dete and place, end due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end place, end due to the cause(s) end manner stated.

29c. License number

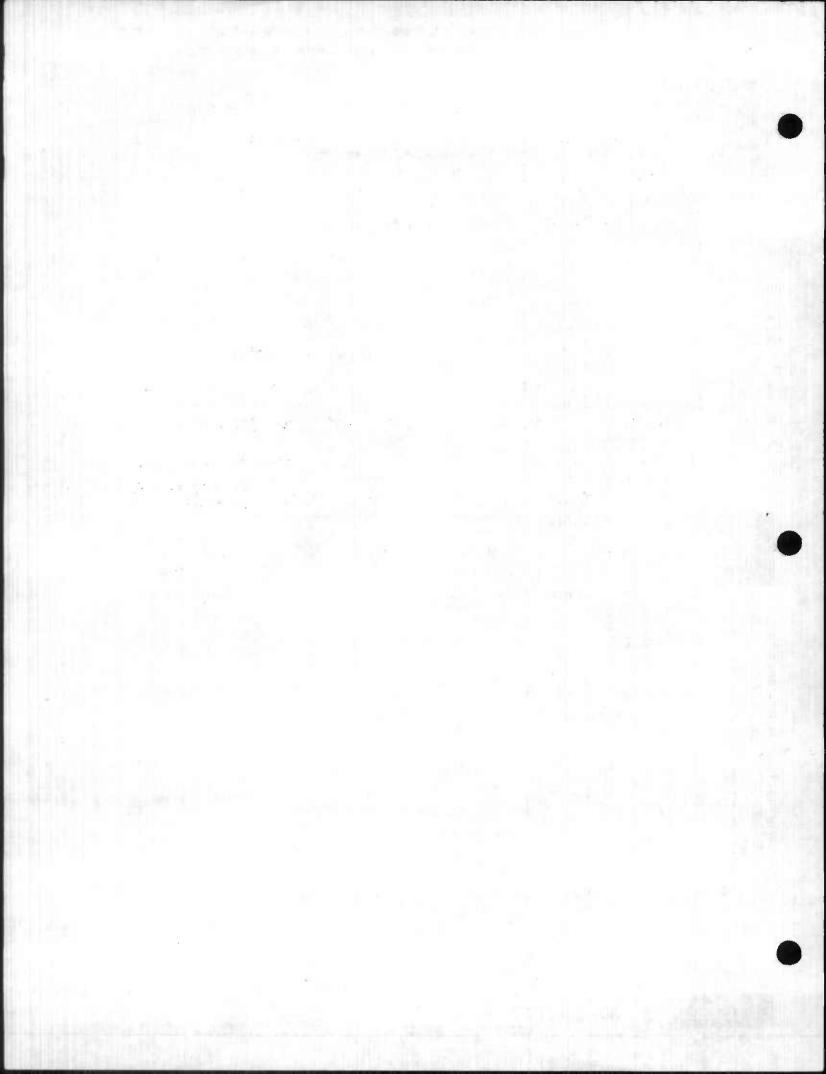
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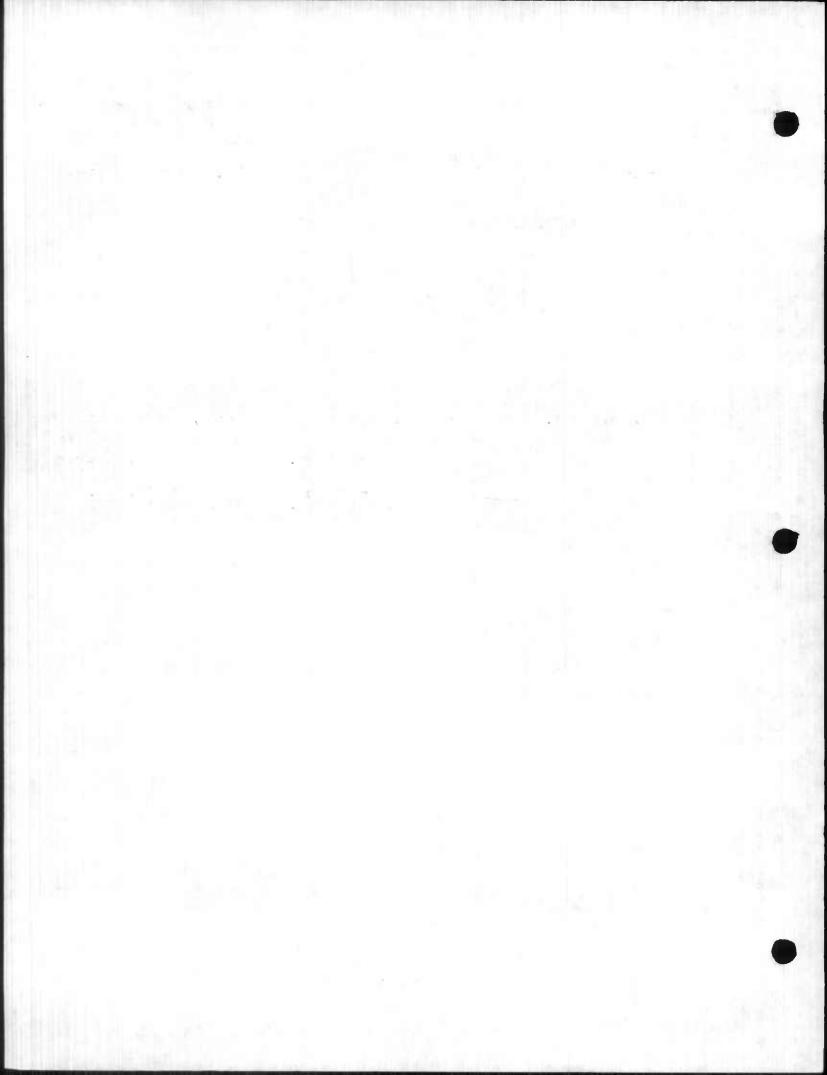
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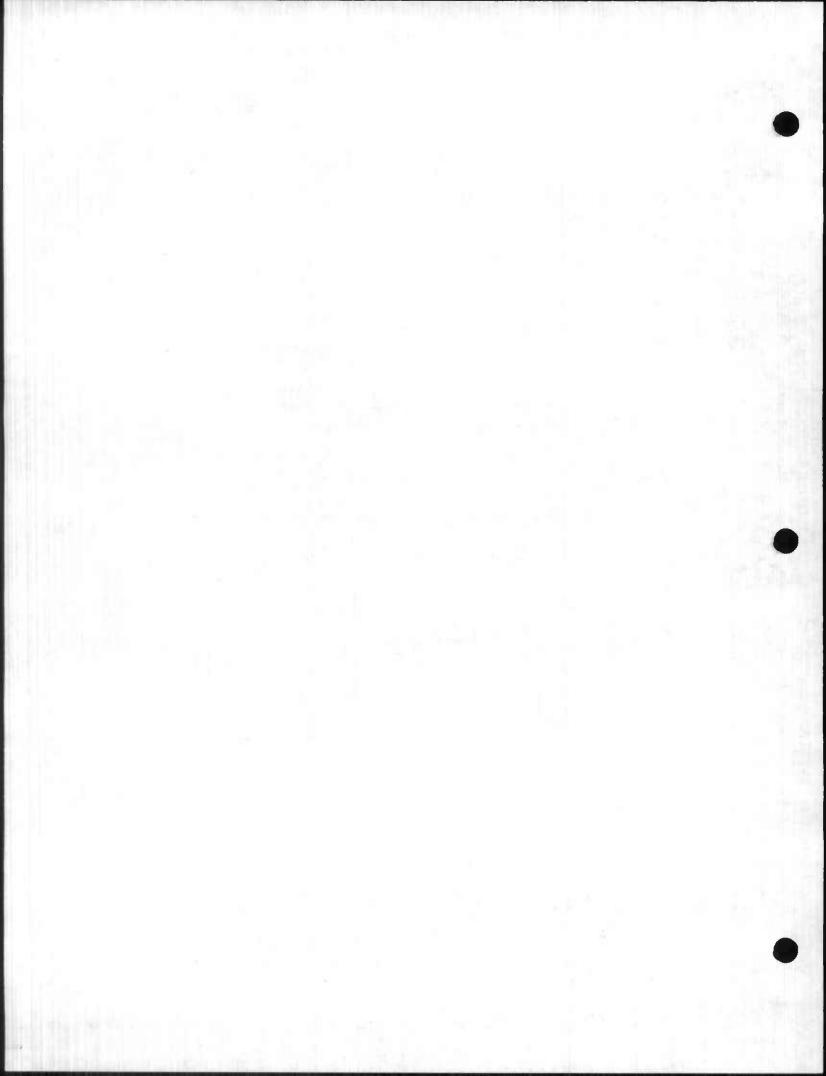
State of Maryland / Department of Health and Mental Hygiene 00 36368

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aminer	4a Facility Name (If not institution, g BAYVIEW HOSPIT		m <i>ber)</i>						cation of Death CITY	4c. County	of Death	N/A	
ral tor	5. Social Security Number 217-28-2421	Sex 1 M 2 □ F	7. Age (In yrs. la 67	st birthdey) Yrs.	If Under Months	1 Year Days		Min.	8. Dete of Birt (Month, De Jan. 2	h y, Year) 9,1933		lace (State on try)	or Foreign
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ctor	10a. State 10b. County Maryland Ba	ltimore	10c. City,	Town or Lo	ocation	Du	ındalk				1	0d. Inside Ci	
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o Be	Raymond Leo									ougheno			
F	19a. informant's Name/Reletionship Mrs. Barbara	(Type, Print)	Wife		-		t end Numbe	er or Rural	Route Number	er, City or Town	, Steta, Zip	Code) 21222	
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edical (aminer: On the b	a best of my knowl asis of examinationar stated.										s)
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State	30. Neme and address of person with TACK W. TIT 31. Date filed (Month, Dey, Year)	15, M.D.		Penn		et,	Baltin	more,	Maryla	and 2120	01		

Registrar



		Certificate of Death	Reg	j. No.	6369
	Physician	1. Decedent's Name (First, Middle, Last) Lena Rose Culotta	2. Dete of Death Month November	Day Year 14, 2000	3. Time of Death 13:37
	/Medical Examiner	4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Lo	cation of Death	4c. County of Death	13.37
		Harford Memorial Hospital Havre de G 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs.		Harford	ines (State or Foreign
	Funeral Director	213-30-7993 1 M 2 M F 69 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y Feb. 22, 1	931 Mary	lace (State or Foreign try) land
	yland M M	Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location		1	0d. Inside City Limits
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				p. Citizen of What Coun Inited State	
	020 our after douth v art, or fems 23 Examiner must by Funeral	If Yes, Give 1 ☐ Yes 2X No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, of Specify: Whi	etc.
	Maryland 21215-0020 d 2 should be flied within 72 hours all in and Mental Hygene. T is marked other than "natural", or traumatic event, the Medical Exami To Be Completed by F	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Report Reviewer		Bb. Kind of Business/Inc Baltimore Colice Depa	ity
	land a led be fled lents! Hygine see other ic event, I	17. Father's Neme (First, Middle, Last) 18. Mother's Name	First, Middle, Ma	aiden Sumeme)	
1	farylar 2 should b and Ments is marked surrette a				0-41
Str	Mar nd 2 sh alth and 27 is m	19a. Informant's Name/Reletionship (Type, Print) Diane Lynn Paugh/ Daughter 19b. Meilling Address (Street end Number or Rure) 1133 Revolution St. Have			1078
0	Baltimore, semit. Pages 1s apparatus of He moortants if then my Injury or other sites.	20a. Method of Disposition 1 Burial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Chesapeake Crematory, Inc 1.		Beltsville,	
410	Balt Depart Import any inj	21. Signature of Funeral Service Licensee Laura C. Hardes Ty 22. Name and Address of Facility CAFA Stephen D. Loh: 8717 Green Pastures	rmann P.A	A.	D 21206
-		23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.	or respiratory erres	attimore, r	Approximate Intervel Between
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13	68760, filests be executed filests be executed to physician and as the burial-transfedical Exami	Sequentially list conditions, if any, leading to immediate couse. Enter Underlying Ceuse (Disease or injury that initiated events			
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	Dia • Hospital or • 24 hours after • Funeral Direction of the property filled in perfect of the perfect of t	29a. Certifier 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, (Check only one) 2☐ Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurr and manner stated.	red at the time, dat	te and place, and due to	the ceuse(s)
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	To the Hosp within 24 hosp within 24 hosp completely f	29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and didress of person who completed ceuse of death (Item 23a) (Type, Print)	red at the time, dat	te and place, and due to	o the ceuse(s)



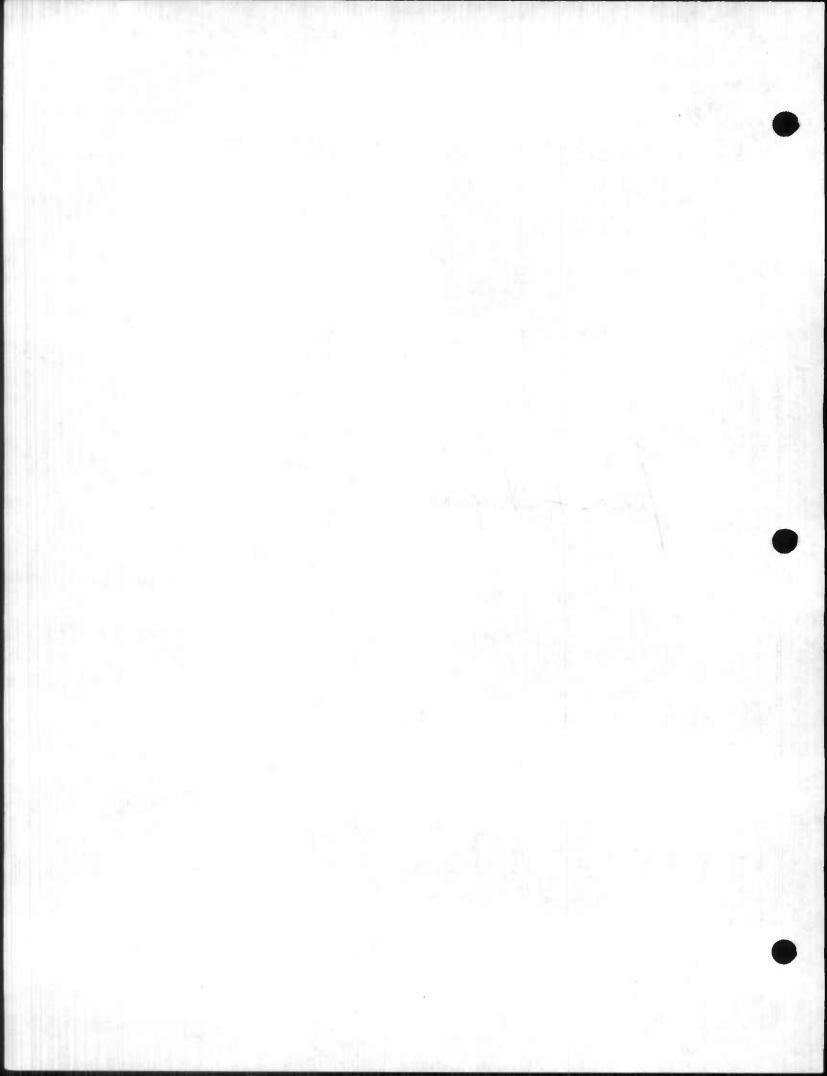
State of Maryland / Department of Health and Mental Hygiene

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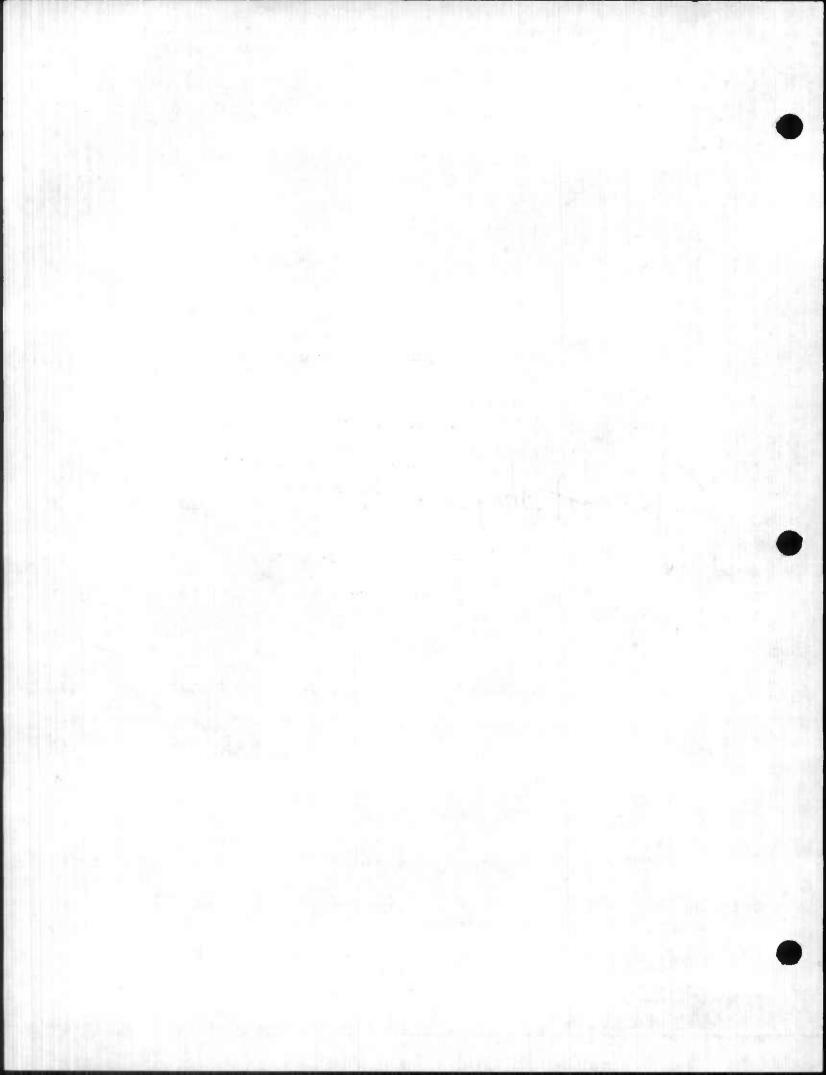
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	1. Decedent's Nema (First, Middla, Last)	DESCRIPTION				2. Data of De		Vaa-	3. Time of Death
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be notified	10e. Street and Number		10f. Zi	p Code			10g. Citizen of V	Vhat Count	ry?
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State of Maryland / Department of Health and Mental Hygiene 00 36371

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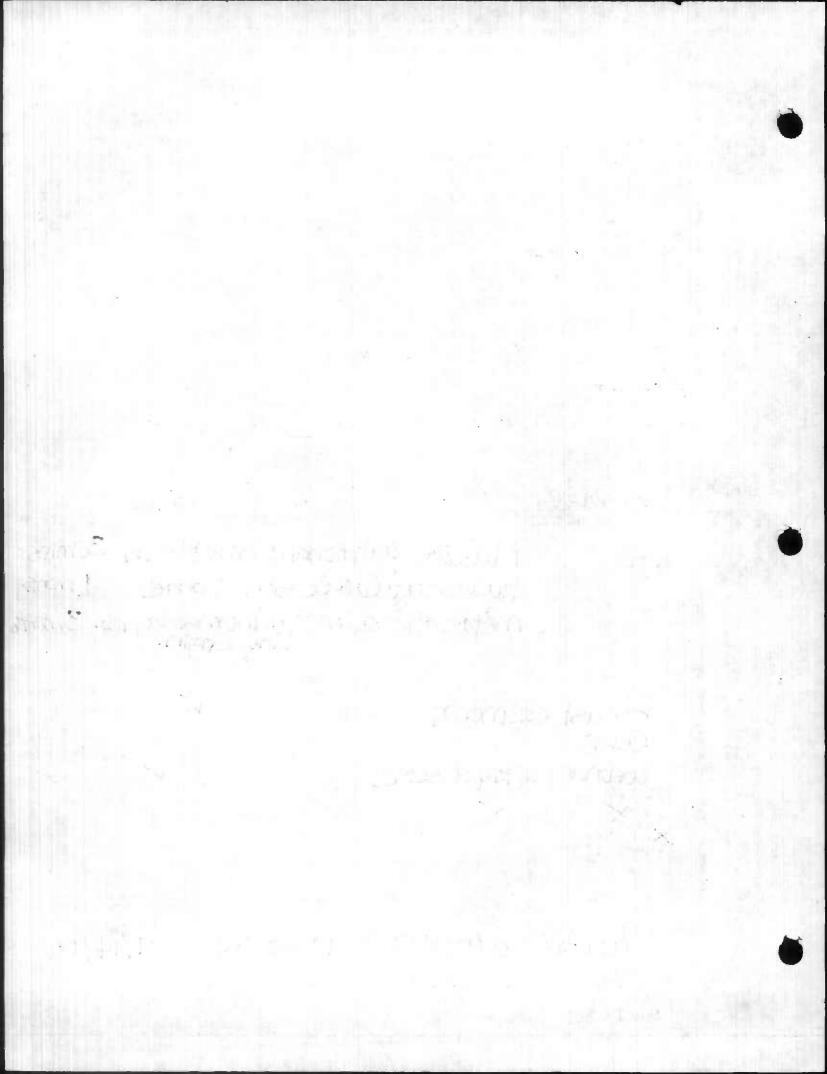
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التي	Decedent's Neme (First, Mi	iddle, Last)	C	ertificate of	Death	2. Dete of Deeth	J. No.	3. Time of Death
Physician /Medical	AGNES S. CONNE					Month Novembe		Year 2:20pm
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	Greater Bal				Towson If Under 24 Hrs.	Danie of Bish	Balti	
uneral rector	5. Sociel Security Number 214-24-7731	1□M XXF	Age (fn yrs. last birthda 72 Yrs.	Months Deys		8. Defe of Birth (Month, Day, 4-4-192	(ear)	9. Birthplece (Stete or Foreign Country) Maryland
11	Usuel Residence of Decedent 10a. Stete 10b. Cou		10c. City, Town or	Location				10d. Inside City Limits
tor.	Maryland Bal	timore		Baltim	nore Count	у		1 ☐ Yes 🌂 💢 No
al Director	10e. Street and Number 7171 Greenwoo	d Avenue		10f. Zip Code	21206	10	g. Citizen of Wi USA	hat Country?
by Funer	11. Merital Stetus 1 Never Merried XX N 3 Widowed 4 Divorce	If Yes Give	X No	B. Was Decedent of I If Yes, specify Cub		ecify Yes or No- Rican, etc.)	Bleck	- American Indian, , White, etc. White
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Baltimore, Maryland 21215-0020

P.O. Box 68760

Division of Vital Records.

Please Type or Print in Black Indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Dorothy Ann Downs 12, NOVEMBER 2000 11:15 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Name (If not institution, give street end number) **Examiner** Saint Joseph Medical Center Towson Baltimore 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Deta of Birth (Month, Deys Hours Min. May 17 1922 9. Birthplace (Steta or Foraign Country) Maryland 5. Social Security Number **Funeral** 1 M X F 212-20-4256 Director Usuel Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or frame 23a or 28a-f ehor the Medical Examinar must be notified at 1□ Yes 2□ No Baltimore Directo Towson 10e. Street and Number 10f. Zip Code 10g. Cifizen of What Country? 500 Virginia Ave. #1301 21286 USA 14. Race - American Indian, Black, Whita, etc. "natural", or items 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yas or No. If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 11. Maritel Status 1 ☐ Yas 2 ☑ No If Yes, Give X 1 Nevar Married 3 Married 1 Yes 2 No Specify. White P 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) Claims Adjuster Insurance 12 other 17. Fathar's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If flem 27 is marked oth any Injury or other traumatic event alose. Be Edward Parrish Achsah Preston Cockey 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stete, Zip Code) James T. Downs/husband 500 Virginia Ave. #1301, Towson, MD 21286 20b. Piece of Disposition (Name of cemetery, crematory or other piece) 20c. Location - City or Town, Stata 20e. Mathod of Disposition 11/16/00 Buriai 2 Cremetion 3 Removel from Stete Dulaney Valley Memorial Gardens Timonium, MD 21 Signature of Funeral Service Ucens 22. Nama end Addrass of Fecility Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093 that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, on each lina. Approximate Interval Between Onset and Deeth 23a Part1. Enter the disease, or complic METASTATIC BREAST CARCINOMA /Medical Immediate Cause Final disaasa or contill resulting in deeth) Due to (or es e consequence of): Examine the burial-transit Due to (or as e consequance of) physician and

Physician Examiner

> Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initialed events resulting in death) Last edical Physician/M signed by the a p

Completed

To

Medical Certification:

page 2

after death.

Director: After this certific

To the Hospital owithin 24 hours a To the Funerel D

Dua to (or es a consequence of)

Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Vinknown

281. Location (Street and Number or Rural Route Number, City or Town, Stete)

24a. Wes an autopsy performed?

24b. Wera autopsy findings available prior to complation of cause of death?

1 ☐ Yes 2 No

1 ☐ Yes 2 No

28. Place of Death (Check only ona)

25. Was cese referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Deeth 1 Natural
2 Accidant

3 Suicide

29e. Certifier

4 Homicide

5 Pending Investigation 6 Could not be detarmined

Hospitei: 1 Inpatient 2 ER/Outpetient 3 DOA 28b. Time of

28e. Plece of Injury - At home, ferm, street, fectory, office building, atc. (Specify)

28c. tnjury at Work? 1 Yes 2 No

Othar: 4 Nursing Home 5 Residence 8 Othar (Specify) 28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledga, death occurred at the time, data and place, and due to tha causa(s) and mennar as stated.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

one)
29b. Signature end titla of certifier

multa m.0

and menner steted.

29c. License number D 41410

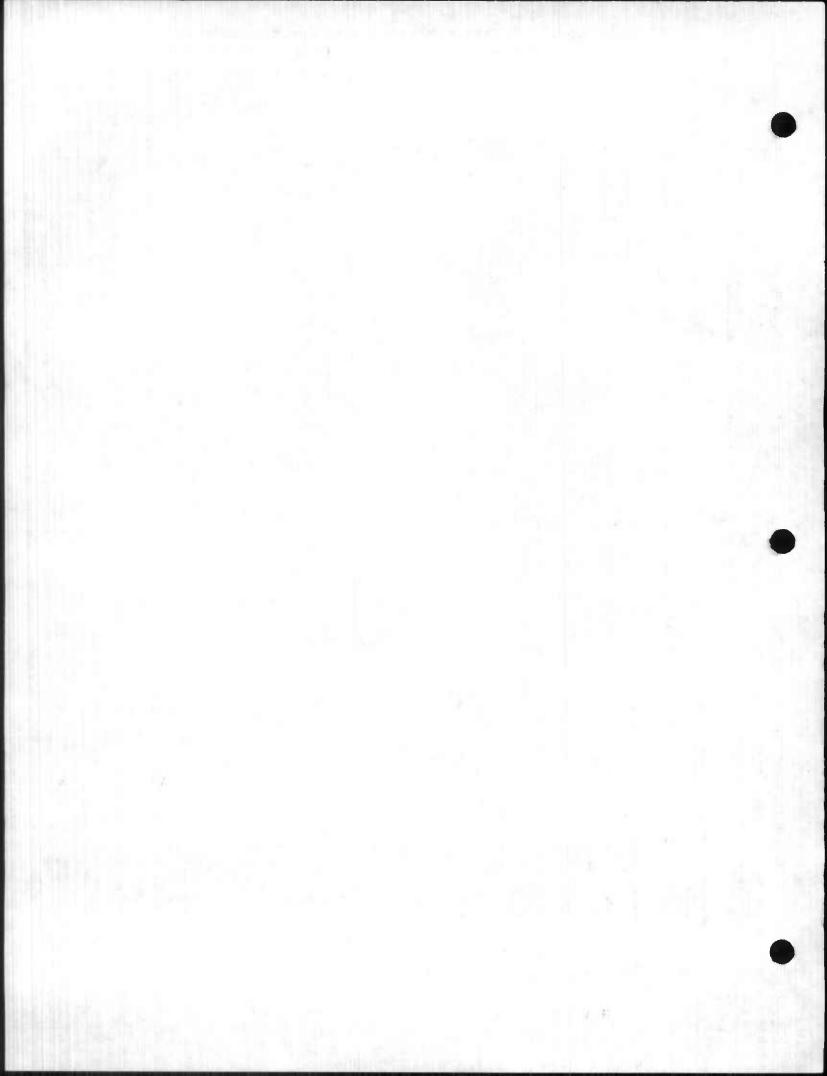
29d. Date signed (Month, Day, Year) November 12 , 2000

30. Neme end address of person who completed ceuse of deeth (Item 23e) (Type, Print)

JOGINDER P. MEHTA, M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204

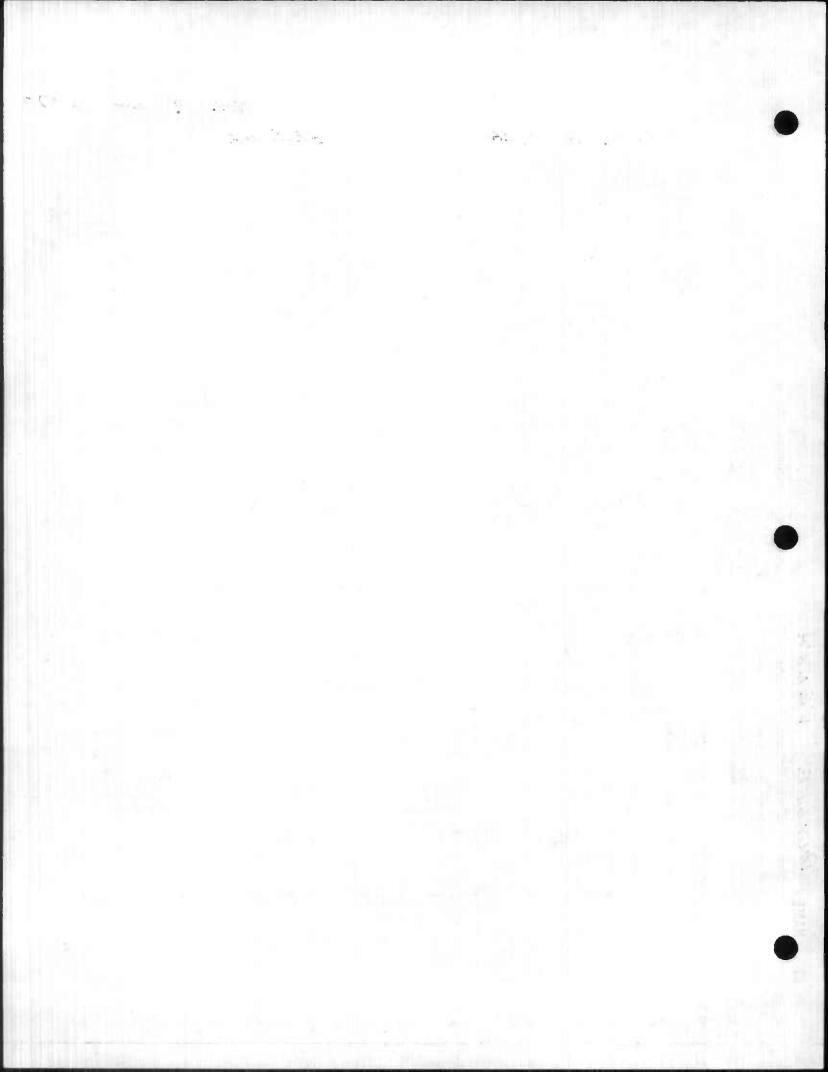
Registrar

32. Registrar's Signature



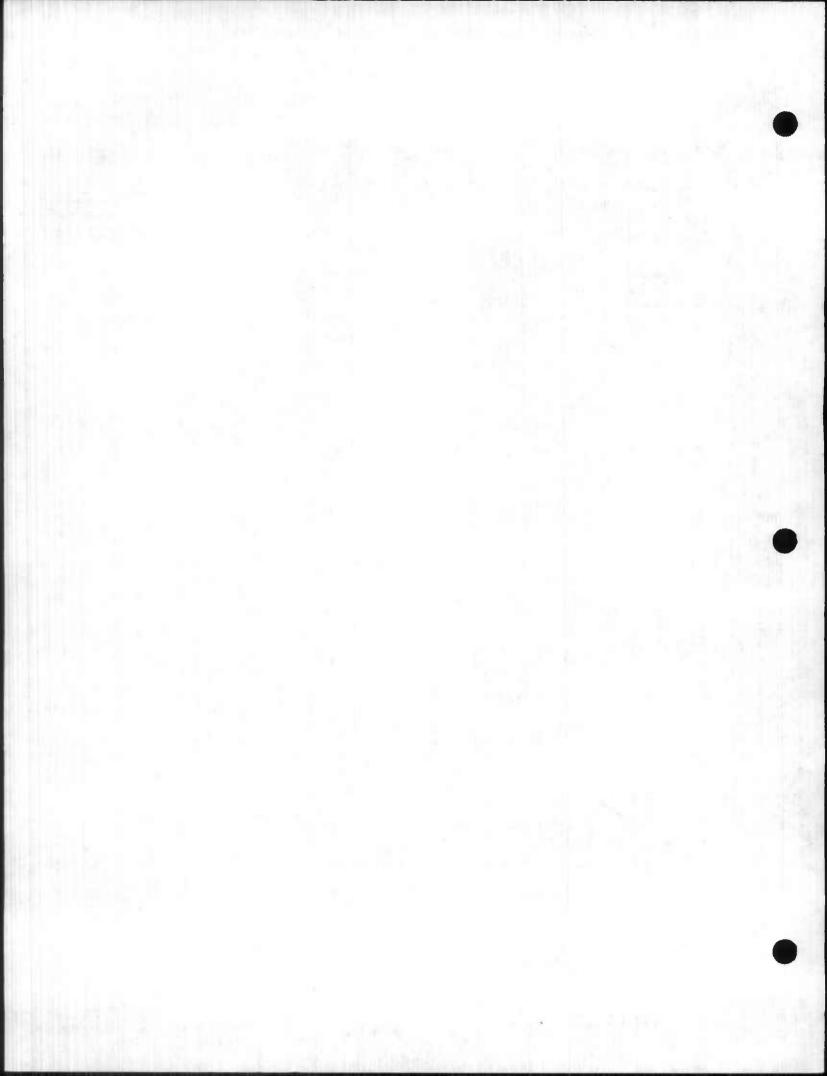
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Cert	tificate of	Death	Reg	. No.	0 3	6375
Dhuaisian	1. Decedent's Neme (First, Middle, La					2. Date of Death Month	Dev	Year	3. Tima of Death
Physician /Medical	VERNA	DUNGEE				Nov.	-	2000	20:20
Examiner	4a Facility Name (If not institution, give				4b. City, Town, or Lo		4c. County	of Death	
	ST. AGNES HER	LTh CARE			BALTIMO	RE			
ral	5. Social Security Number 6. S		. last birthday)	If Under 1 Year Months Days		8. Dete of Birth (Month, Day,)	(ear)	9. Birthpla	ce (Stete or Foreign
ctor	212-26-1858	M 200 F 70	Yrs.	MOTRIS Days	Hours Mir.	5-24-1	930	Count	Md
	Usual Residence of Decedent								
miner must be notified at	10a. State 10b. County		ity, Town or Loc	ation				10	d. Inside City Limits
0	Md N/A	Ba	ltimore						1 X Yes 2 No
1	10e. Street and Number			10f. Zip Code		100	. Citizen of V	Vhat Countr	y?
-	5502 Wilvan Av	renue		21207			II S	Λ	
Funeral Director	11. Merital Status	12. Wes Decedent Ever in U Armed Forces?	J,S. 13. W		Hispanic Origin? (Spo pan, Mexican, Puerto	ecify Yes or No-	14. Rac	a - America	
ū	1 Never Married 2 Merried	1 Yes 2 No		Yes 2 ∅ No		rucan, etc.)		k, White, et	
9		If Yes, Give Year or Dates:		LITES ZIMINO	эрвану:		Specify	Blac	CK
To Be Completed	15. Decedent's E	ducation	16a. Decede	ent's Usual Occu	pation during most of work	16	8b. Kind of Bu	sinass/Indu	ıstry
9	(Specify only highest grave) Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retire	ed)	10			
0	12th grade	N/A	Hous	sewife			Home		
9	17. Father's Name (First, Middle, Last				18. Mother's Name	(First, Middle, Ma	aiden Sumem	10)	
C	McKinley Hood				Vivian	White			
	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Stree	t and Number or Run	al Route Number,	City or Town,	Stete, Zip (Code)
	Bernadette C. Dun	goo Daughton	EEOO	1.12.1	A B	altimore	Md :	21207	
	20a. Method of Disposition	yee-vaugnter 206.1	Place of Dispos	Wilvan ition (Name of atory or other pla	Avenue	altimore 20	c. Location -	City or Tow	m, State
	1 Burial 2 ☐ Cremation 3 ☐	IHAMOVAI IMM STATA				1-17-00	Ashuti		A -3
	4 Donetion 5 Other (Specif			Name and Addr		1-1/-04	Arbuti	15 , 1	7IU
DOC 8	111 0		l N	larch F/	H Wast				
	23a. Peril Enter the crumse, or communication or heart failure. List only). Harm		1300 Wab	ash Avenu	e Balt	imore.	, Md	21215
	23a. Peri Emili the damse, or com	plications that caused the dear one cause on aech line.	th. Do not enter	the mode of dy	ing, such as cardiac o	or respiratory arres	it,		Approximata ntarvel Between
n									Onset and Death
ıl I	Immediate Causa (Final disease or condition	PMI	EUM	ONIA					
er .	resulting in death)		or as a consequ						
ne		, CHRONU	065	TRUCTI	VE PULM	OMARY	DISGA	2F	
E	Sequentially list conditions,	-	or as a consequ						
EX	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury							i	
edical Examiner	that initieted events resulting in death) Last	Due to (c	or as a consequ	ence of):					
Aed	testing in death) Last							i i	
Z		d							
Physician/	Pert II. Other significant conditions of	ontributing to death but not re-	sulting in the une	derlying cause o	iven in Part I.	23b. Did tob	acco use co	ntribute to	the cause of death?
hve	The second secon	The second second	111111	3 - 100 9					ably 4 Unknow
by P	REMAL IN	SUF FICKETY	cy						
	CONT. TO SERVICE					24a. Was en		24b. Wer	e sutopsy lindings
lete						performe	ed?	con	leble prior to pletion of cause eath?
Completed									
S						1 Yes	2 No	10	Yes 2 No
89	25. Wes case referred to medical examiner?	Hoenitalı		la.		h (Check only one)		
2	1 ☐ Yes 2 ☑ No		ER/Outpatient	3LJ LOA	-	me 5 Residen			
	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	ary at ork?	28d. Describe how	injury occur	red	
cation:	2 Accident investigation				Yes 2 No				
tiffic	3 Suicide 6 Could not b	28e. Place of Injury - At h building, etc. (Speci		et, fectory, office		281. Location (Stre	et end Numb State)	er or Rural	Route Number,
Certiff		Canada, atc. (opaci	-,/		4 10 3 1				
	29a. Certifier 1 Certifying Ph	ysician: To the best of my kno	owledge, death	occurred at the t	ime, date and place,	and due to the cau	sa(s) and me	nner as sta	ited.
edical	(Check only 2 Medical Exam	niner: On the basis of examina and manner stated.	ation and/or inve	estigation, in my	opinion, death occurr	ed et the time, dat	e end pleca,	end due to	the cause(s)
N	29b. Signature end title of certifier			29c. Licen	se number	290	d. Data signe	d (Month, D	ley, Year)
	1 Bolomul	mo		101	13595	i	Voven	4350	9 7000
/	1000		m 93a) (To 7					-17C PC	9, 2000
1	30. Name and addrass of person who	-			Han C dia	0	21.7	Ma - M	-
1	31. Date filed (Month, Day, Year)	32. Registrar's Sign		14 recs	1402114	14 15	FILI	more	. 6
tate		Je. Hogistial's Sign							
gistrar	NOV 1 6 ZUUU	Dens /	9 00	arked					



ysician Medical da Financia de Control de Co	Isla Residence of Decedent State State Tyland Street and Number 2700 North Char Marital Status In Never Married Specify only highest grade and the status In Status In Never Married Specify only highest grade and specify only highest grade and specify only highest grade and specific specify only highest grade and specific specify only highest grade and specific specif	re street end number) newOod Sex 7. Age (In yrs 82 10 C Fut 12. Was Decedent Ever in Armed Forces? 1 Yes 2 No It Yes, Give Year or Dates: ducation and completed) College (1-4or 5+) 4 College (1-4or 5+) Print) ewic, niece Removal from State fry) nsee And policetions that caused the decone cause on each line.	U.S. 13. 16a. Decc. (Give life.) Nur: 19b. Mail 990 Place of Disp cemetery, crecedowric	Months cation re of 101. Zip 212 Was Decetiff Yes, spect I Yes dent's Usua kind of wo DO NOT us see ng Address) 11th position (Narmalory or of the Control of the C	Home of Code 218 Sent of Hickory Cubar 22 No at Occuper's done of se retired, and Address Se Full Hammodie of dying de of dyi	altimor If Under 24 H Hours N H Hours N H Hours N H Hours N H H H H H H H H H H H H H H H H H H H	Raltiom (Specify Yes or verto Rican, etc.) Working Name (First, Midden Hegarty Rural Route Nurasadena, Date k 11-17- Home of crry Road	Der 14, 2 path 4c. County Birth Vear) 3/1918 re City tog. Citizen of U. No- 14. Rai Bla Specif 16b. Kind of B Health dle, Maiden Sumar MD. 211 20c. Location -00 Elk Lansdown I Lansdown Lansdown Lansdown	y of Death N/A 9. Birthplace (State or a Country) Maryland 10d. Inside City 1 1 Yes 2 What Country? S.A. ce - American Indian, ack, White, etc. White Susiness/Industry Care me) 1. State, Zip Code) 2.2 - City or Town, State cridge, MD
Medical daminer 4a F 5 90 10a 10a 10a 10a 10a 10a 10a 10a 10a 10	Facility Name (If not institution, giver Future Care Homocolal Security Number 20-09-0562 Ital Residence of Decedent State 10b. County N/A Street and Number 2700 North Chare Marital Status In Never Married 2 Married 3 Widowed 4 Divorced (Specify only highest gradiementary/Secondary (0-12) 12 Father's Name (First, Middle, Last, James Dolan and Internation 1 Dolan 1 Donation 5 Other (Specific Signature of Funerel Service Licer Signature of Funerel Service Licer Signature of Funerel Service Licer Shock, or heart tailure. List only mediate Cause (Finat ease or condition ulting in death)	Type, Print) Elemoval from State by) Removal from State by)	U,S. 13. 16a. Dece (Give life Nur: 19b. Mail 991 Place of Disposemetery, cree adowrice adowrice adowrice adowrice the Do not er	Months cation re of 101. Zip 212 Was Decetiff Yes, spect I Yes dent's Usua kind of wo DO NOT us see ng Address) 11th position (Narmalory or of the Control of the C	Home of Code 218 Sent of Hickory Cubar 22 No at Occuper's done of se retired, and Address Se Full Hammodie of dying de of dyi	altimor If Under 24 H Hours N H Hours N H Hours N H Hours N H H H H H H H H H H H H H H H H H H H	or Location of Dece City Trs. 8. Dete of Month, 04/13 Baltiomn (Specify Yes or Jerto Rican, etc.) working Name (First, Midd Hegarty Rural Route Nural addena, Date k 11-17- Home of crry Road	Birth Vear) 3/1918 Ce City 10g. Citizen of U. No- 14. Ran Bla Specif 16b. Kind of B Health dle, Maiden Sumar MD. 211 20c. Location -00 Elk Lansdown	y of Death N/A 9. Birthplace (State or a Country) Maryland 10d. Inside City 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
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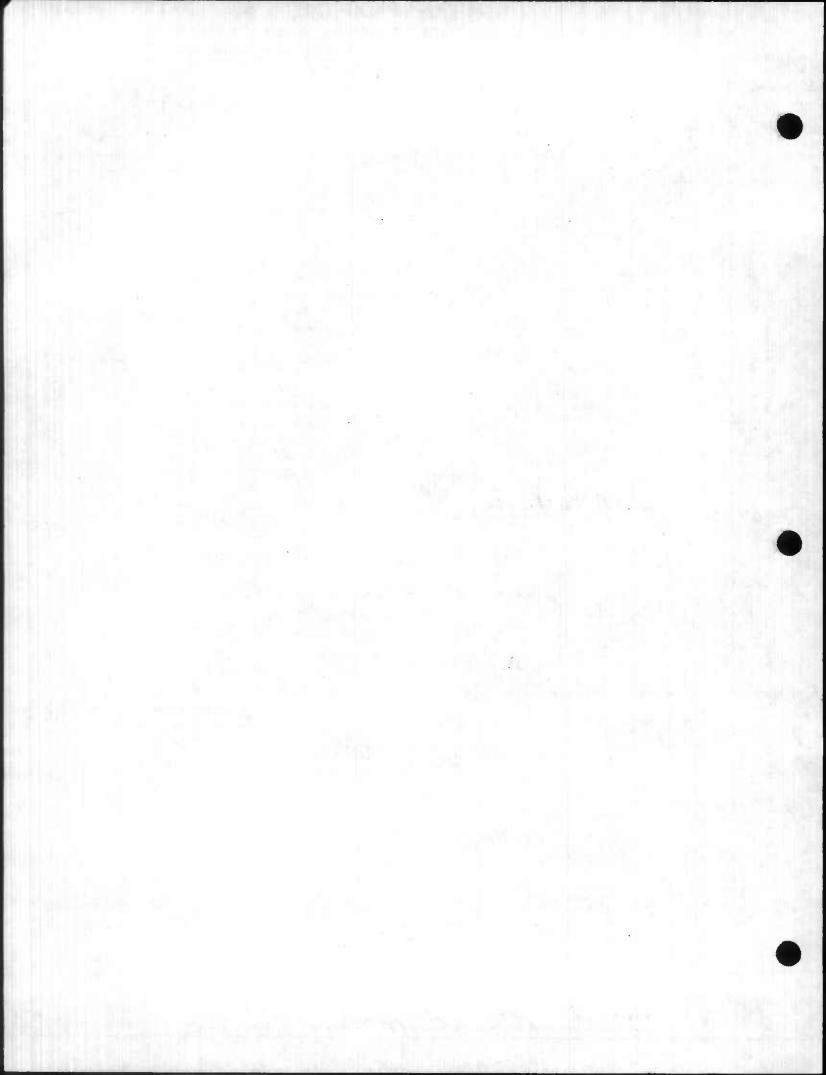


State of Maryland / Department of Health and Mental Hygiene 0 0 36377

Certificate of Death

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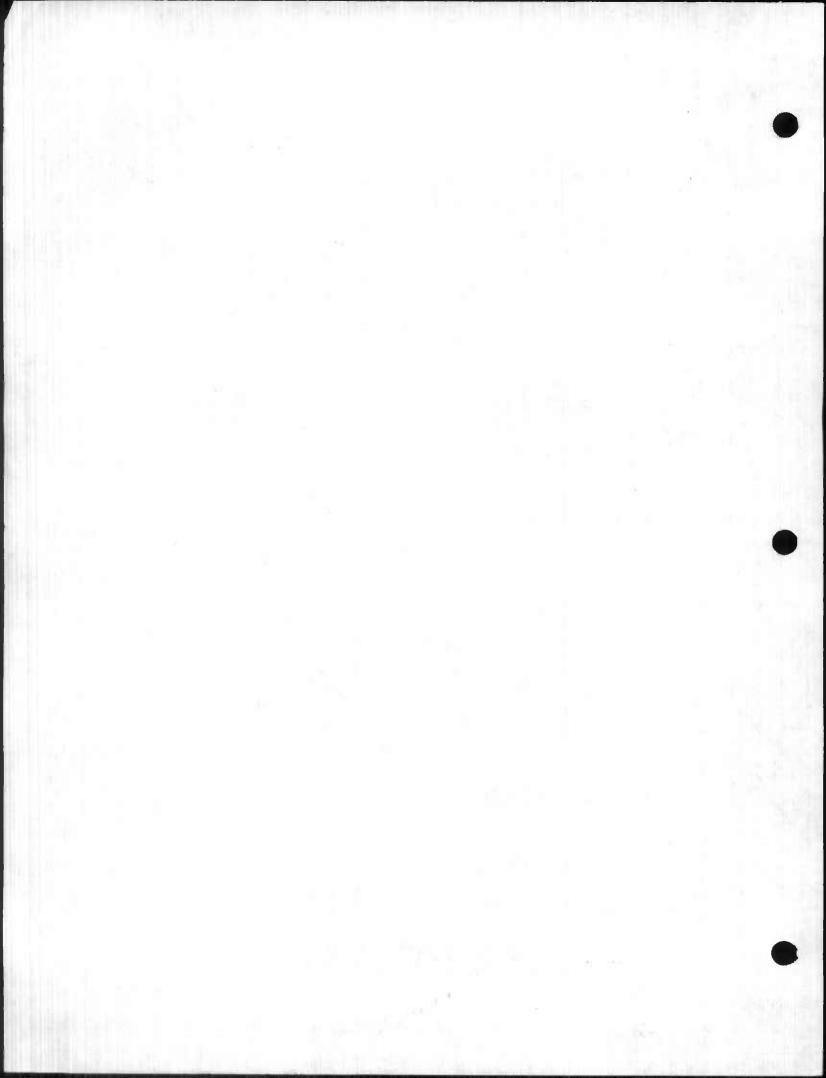
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 1 26278

ICE			Certificate	e of Death	Reg. No.	30370							
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	Examine	4e Facility Name (If not institution, give: NORTHWEST HOSPITA		Randalistow		IMORE							
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	with the Maryland a or 28a-f show be notified at	10e. Street and Number	10f. Zip	Code / / /	10g. Citizen of V	What Country?							
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/lan	Mental Hyginarked other	James H. Fonce	James H. Fonce Louella James										
Maryland	2 sho	19e. Informent's Name/Relationship (Ty	pe, Print) 19b. Malling Address	(Street end Number or Rural R	Route Number, City or Town,	Stete, Zip Code)							
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	西班莱克 / 4												
	5 1 3		11/200	OCME		NOVEMBER 13, 2000							
	1/1/	30. Name and address of person who co	mpleted cause of 19th (Item 23a) (Type, Print)										
	/ h.)	THENDRE M.Kin		treet, Baltimo	re, Maryland	21201							
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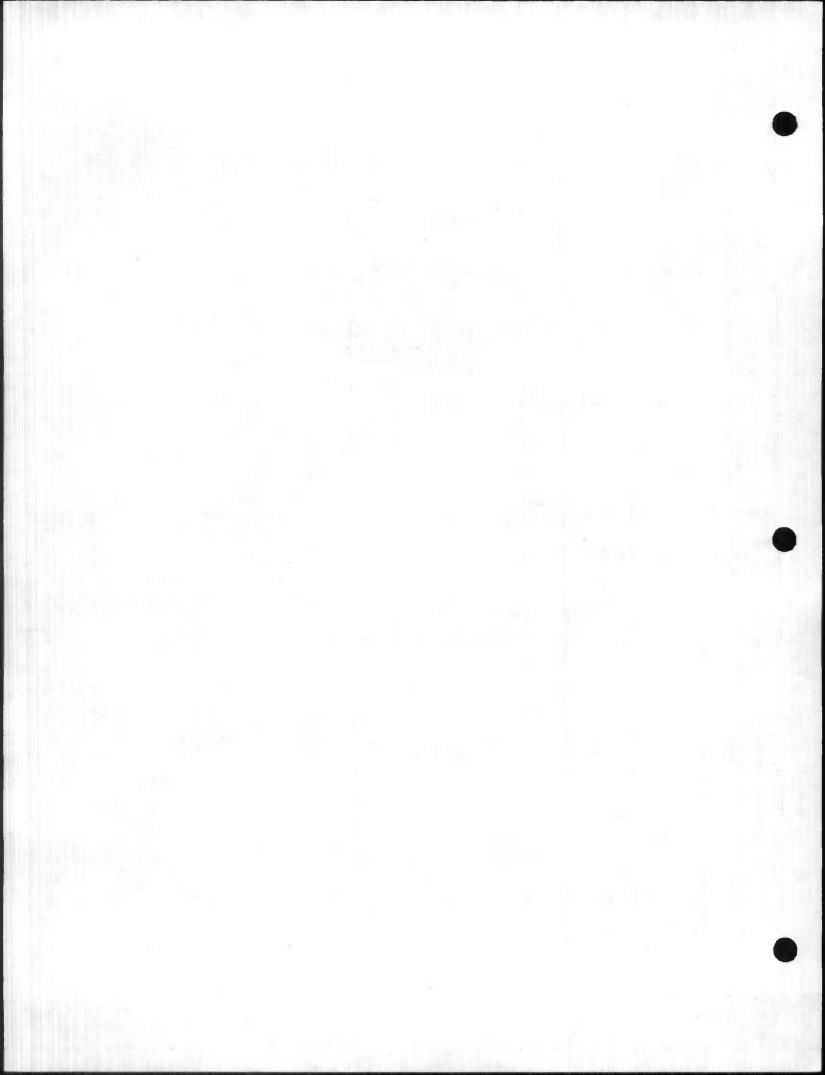
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5			1.						y Martin				
	19a. Informant's Name/Relationship Deborah Forbes,				-					nore, M			
	20a. Method of Disposition Date Date 20c. Location - City or Town, State												
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	Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of):									28 Day			
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rector, page 2	25. Was case referred to medical						26. Place	of Death (Check only or	ne)			
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N S	29b. Signature and titla of certified 29c. Licanse number									29d Date signe			
/1		Julue	. NO			0_	135	92		Nov	15.	2000	
23	30. Name and address of person wh	1			, Print)			0				000	
V	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A-LE-XANDER JOHNSON, 900 CA-TON AVE. BALTIMORE 21229 31. Date filed (Month, Day, Year) 32. Degistrar's Signature											124	

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State of Maryland / Department of Health and Mental Hygiene 36380 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death November 14, 2000 **Physician** Warren J. Feinour 4:30 AM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3075 Deepwater Way Harford Edgewood If Under 24 Hrs. 8. Data of Birth (Month Day Year) 7/26/1923 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days Hours 214-20-5584 1X M 2□ F Months Maryland Director Usual Rasidence of Decedant 10b County 10c. City, Town or Location 10d. Inside City Limits MD Harford Edgewood 1 ☐ Yes XX No Director 28a-f 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ð must be 3075 Deepwater Way Itserns 23a 21040 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 Yas 2 No If Yes, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, etc. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 natural, or Specify: White 1 Yes 2 No Specify: À 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tile. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiane. Elamentary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygiens Important: if flem 27 is marked other tha any Hyllury or other traumatic Superintendent Construction 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas Feinour Ethel (Unknown) 19a. Informant's Neme/Raiationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Stewart/Daughter 3451 Alban Towne Way Edgewood, Maryland 21040 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Steta 1 Buriai 2 Cramation 3 Removal from Stata Gardens of Faith Cemetery 11/16/00 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility John C. Miller Inc. 21. Signature of Funeral Service/Licensee 6415 Belair Road Baltimore, Maryland 21206 23a. Part 1. Enter the disease, or complications that cause it shock, or heart feilers. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** /Medical immediata Causa (Final disaase or condition rasulting in death) Examiner Examine ician and buriel-transit that the death certificate be executed Sequentially list conditions, if any, laading to immadiate causa. Entar Underlying Ceuse (Disaase or injury that initiated events rasulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical Dua to (or as a consequence of) the signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4 NUnknown þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 s 1 ☐ Yes 2 ☐ No Division of Vital Physician: 25. Was casa referred to medical examiner? Be group Hone 26. Place of Death (Check only one) To Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No Hospice this 27. Mannar of Daath 1 Desatural 2 Accident 28d. Describe how injury occurred 28b. Time of Injury ne Hospital or Attending Pi 0.24 hours after death. The Funeral Director: After the pletely filled in by the funeral Certification: 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending invastigation 1 TYes 2 □ No 6 Could not be 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the bests of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Cartifier Medical (Check only one) 29b. Signatura and titla of certified 29c. License number 29d. Data signed (Month, Day, Year) 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) 3004 Abington Emmorton Mord 31. Data filed (Month, Day, Year) 32. Registrar's Signature State Registrar

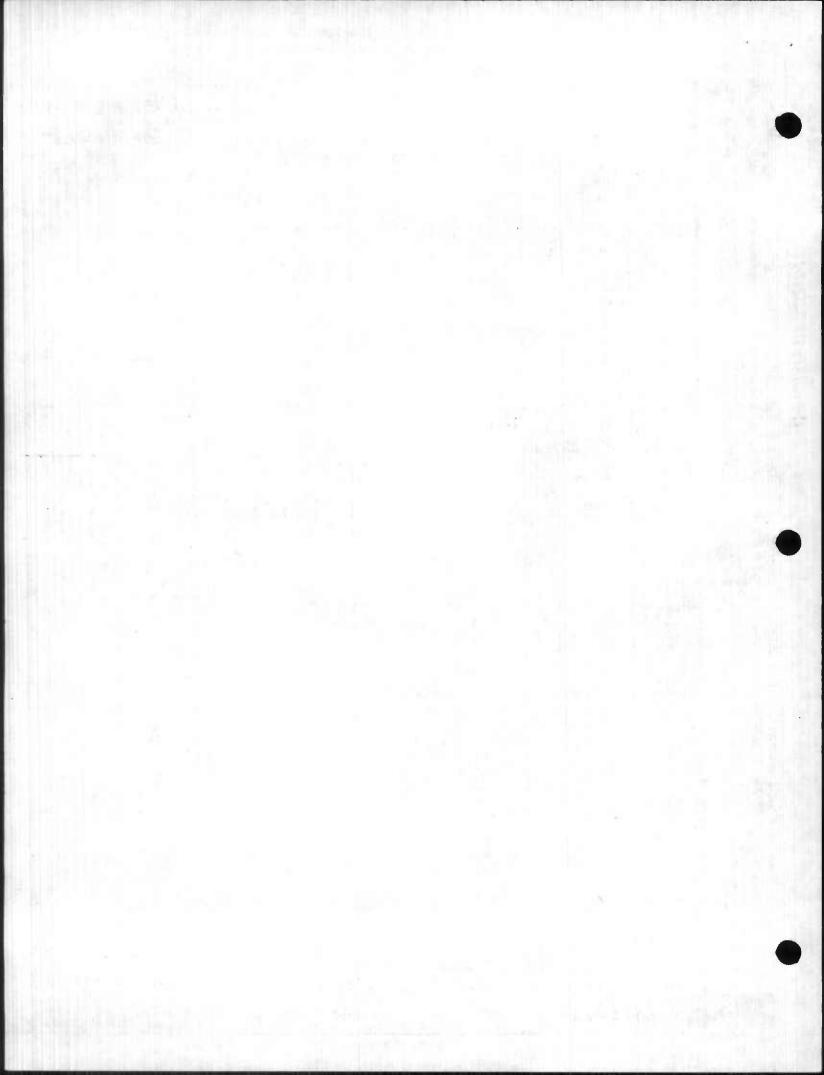
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

		H. G789 11–16–2000	JAB Certific	cate of Death		Reg. No.	10.5					
Physician	Decedent's Name (First, M	ddle, Last)			2. Dete of De	Day	Year					
/Medical	JOHN GIANOT	TI		th City Town	November Location of Death		2000 12:54 P.					
Examiner	FRANKLIN S	and the second second	ITAL CENT	0			LTIMORE					
Funeral	5. Social Security Number		(In yrs. last birthday) If U	Inder 1 Year If Under 24 h	Irs. 8. Dete of Birt		9. Birthplace (State or Foreig					
Director	219-26-6621 Usual Residence of Decedent	1 1 M 2 □ F	60 Yrs. Mor	nths Days Hours M	in. Month, Da	0,1940	Maryland					
ě w	10a. State 10b. Cou		10c. City, Town or Location				10d. Inside City Limits					
to Tot	Md Ba	HIMORO	PARKVILL	9			1 Yes 28 No					
or 28a-f s be notified Director	10e. Street and Number		10	f. Zip Code		10g. Citizen of WI	hat Country?					
rai is	1941 MOW	Hain AV.		2/234		US	A					
r Nems 23s	11. Maritel Status	12. Wes Decedeni Eve Armed Forces?	if Yes,	Decedent of Hispanic Origin? specify Cuban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)		- American Indian, , White, etc.					
by		If Yes, Give	1 🗆 Y	es 200 No Specify:		Specify:	White					
ygiene. ner than *naturi r, tr = Wedeel Completed	15. Dece (Specify only hij	dent's Education phest grade completed)	16a. Decedent's (Give kind	Usual Occupation of work done during most of a DT use retired)	vorking	16b. Kind of Bus	iness/Industry					
mp lan	Elementary/Secondary (0-1		life. DO N	OT use retired)		Local 1	101					
Hygiene. off, green	17. Father's Name (First, Midd	die. Last)	Carpo	18. Mother's N	leme (First, Middle,	Maiden Sumame	UGERS LINOI					
it health and whette hygiene. Item 27 is marked other than "natural;, other traumatic event, in a because To Be Completed by		10 HIANN	Li '	(0)	conlin	7 (0)	lanks					
aumati aumati	19a Informant's Name/Relati	onship (Type, Print)	19b. Meiling Ad	dress (Street end Number or	Rural Route Numb	gr, City or Town, S	State, Zip Code)					
Health or Bm 27 Ia ther trau	Shiplou.	Lianotti	1941 1	10 when A	We Bal	HIMORO	Md 2123					
	20a. Method of Disposition		20b. Place of Disposition cemetery, cremetory	(Neme of or other plece)	Date 17	20c. Location - C	city or Town, State					
7 or 17 or 1	4 Donetion 5 Other	on 3 Removel from Stele (Specify)	Moreland	Hom. PAPK	2000	PARKVI	Le Lyextime					
Department of Important: If any Injury or phos.	21. Signature of Furieral Serv	ice Licensee	1 22. Nan	ne and Address of Facility	Yans F	unera	a Chapel					
2 5 5 8	APLS41	11/1/00	18 280	30 Haplas	00 DO 1	Saltemi	100 MA 212					
	23a. Part1 Enter the disease shock, or heart failure.	, or complications that caused the List only one cause on each line.	e death. Do not enter the	mode of dying, such as card	fiac or respiratory a	rest,	Approximate Interval Between					
ysician							Onset and Death					
Medical - aminer	Immediate Cause (Final disease or condition resulting in death)	a. Lu	WG CANCE	9			1					
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nsit		0.	BESTOSIS	0								
ician and burisHransit al Examír	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury		ue to (or as a consequence									
physician and the burishtra dical Exar	that initiated events		ESOTHELIC ue to (or es a consequence									
_ = =	resulting in death) Last	d										
d by the attending etached for use as Physician/Me	Part II. Other significant con-	ditions contributing to death but r	not resulting in the underly	ing cause given in Part 1.	23b. Did	tobacco usa cont	tributa to the cause of deat					
gned by the be detached by Physic					128	Sea 2□No	3 Probably 4 Unkno					
					24a. Was	an autopsy	24b. Were autopsy findings available prior to					
s been si should					perio	rmed?	completion of cause of death?					
page 2 should					10	Yes 200	1 ☐ Yes 2 ☐ No					
rector, pag	25. Was case referred to med	lical		26. Place of I	Deeth (Check only o		.2.100					
	examiner?	Hospitel:	2 ☐ ER/Outpatient 30	Other	g Home 5 ☐ Resi		r (Specify)					
	27. Manner of Death	28a. Dete of Injury	28b. Time of	28c. Injury at Work?	28d. Describe	now injury occurre	od					
	2 Accident inve	estigation	M									
as after deam. al Director: After the funer of in by the funer Certification:	3 Suicide 6 Co	ermined 28e. Place of Injury building, etc. (y - At home, ferm, street, fo (Specify)	ectory, office	28f. Location (City or To	Street end Numbe vn, Stete)	or or Rural Route Number,					
0 8 E												
5 4 5		fying Physician: To the best of r cal Examiner: On the basis of ex and menner stete	xamination and/or Investig									
Funer etely fill dical		ilies		29c. License number		29d, Date signed	(Month, Day, Year)					
To the Funeral Director. To the Funeral Director. Medical Certifical	29b. Signature and title of cer			- 1		1	/					
To the Funeral I competely filled	29b. Signature and title of cer	-	_	D 31076		NOVEMA	ER 14, 2000					
To the Funering Completely fill Medical	80	son who completed cause of deer	th (Item, 23a) (Type, Print)				ER 14, 2000					
Medical	30. Name and address of pers	son, mD 6830	th (Item 23a) (Type, Print) HOSPITAL	DRIVE, B								

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 00-6501-510 State of Maryland / Department of Health and Mental Hygiene | | MICHAEL GAUSS Certificate of Death ASP 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** NOVEMBER Michael J. Gauss 14 2000 12:50 /Medical 4a Facility Name (If not institution, give street and number)
MARYLAND SHOCK TRAUMA 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) 6. Sex XX M 2□ F 7. Age (In yrs. last birthdey) 53 Yrs. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Feb. 11, 1947 Maryland 214-46-0396 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 25a-f ahow Lnotified at 1 ☐ Yes 2 X No Director Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 25 202 Mt. DeSales Road 21229 Funeral 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11. Marital Stetus 1 Dives 2 □ No If Yes, Give Year or Dates: VICHNAM EXA 1 Never Married 2 Married Specify: White 1 Yes 2 No Baltimore, Maryland 21215-0020 à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Stationary Engineer J.H.U.M.S. permit. Pages 1 and 2 should be the Department of Health and Mental Hyg important: if here 27 is marked other any injury or other traumers other RRSs. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Gauss Ruth Hawkins 19a. Informent's Neme/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Stephanie Reidy - wife 202 Mt. DeSales Road, Baltimore, MD 21229 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2XX remation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory 11/16 Baltimore, MD 22. Name and Address of Facility FINK FUNERAL HOME, PA 21. Signeture of Fun FINK 426 Crain Hwy., SW, Glen Burnie, MD 21061 Kelly GRegory 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart teilure. List only one ceuse on each line. Approximate Intervel Between Onset and Death **Physician** Emshet Voreld He /Medical Immediate Couse (Final disease or condition resulting in death) Examine Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Last Due to (or as a consequence of): Box 68760. Physician/Medical 94 Due to (or as e consequence of): P.O. Pert II. Other algorificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Completed by of Vital Records. 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case reterred to medical 8 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 No Yes 2 No 28b. Time of Injury 28d. Describe how injury occurred Medical Certification: After 1 Netural 5 Pending 1 Yes 2 No 1825 HR investigation Tarid 14/3/00 Director: / 2 Accident 3 Suicide 4 ☐ Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ,202 Mount Desdes

or Attending Physician: Division after death. To the Hospital within 24 hours a Forthe Funeral Completely filled

281. Location (Street end Number of Aurel Acute Number, City or Town, State) To I Mount DESC Aved City soll Many Cond Mardene 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

29b. Signature and titleyof certified

29d. Date signed (Month, Dey, Year) 29c. License number

O.C.M.E ws 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

NOVEMBER 16,2000

Registrar

32. Registrar's Signature

31. Date filed (Month, Dey, Year) NOV 1 6 2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36383 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dev Physician 12:08pm John Green November 12 2000 /Medical 4b. City, Town, or Location of Death 4. Facility Neme (If not institution, give street and number) 4c. County of Death Examiner ranklin Square Hospital If Under 24 Hrs. Conte Haldimore If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours Min XXM 2DF Director 120-26-5228 03 - 29 - 35MD 6 Usuel Residence of Deceden 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 23a-f shor the Medical Examiner must be notified as Yes 2 No Director MD Baltimore 10e Street and Number 10f Zip Code 10g. Citizen of What Country? USA 2220 Red Thorne 21220 Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. 1 ☐ Never Merried 2 Married Yes 2 No 1□ Yes 2□No Specify þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Co. Steelside 8th Grade 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First Middle Last) Be should be Vizer C. Green Margaret Howard 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 2226 Red Thorn Rd. Baltimore, Maryland 21220 Health Item 27 Diane Green Baltimore, 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages MD Burial 2 Cremetion 3 Removel from State Mills Cem. 11-20-2000 Owings VA 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 22. Neme end Address of Fecility 21. Signature of Funeral Service Licar Baltimore, Maryland 21202 1101 E. North Avenue FH WM.C.March 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical SEPSIS Examiner Due to (or as e consequence of): Examiner DECUBITUS LILCER attending physician and for use as the burial-transit requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medicai Due to (or as e consequence of): signed by the a d be detached f 23b. Did tobacco use contribute to the cause of death? Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 1 Yaa 2 No 3 Probably 4 Unknown RENAL FAILURE þ 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed peed CONSTRICTIVE PERICARDITIS I W page 2 hes 1 Yes 2 NO 1 Yes 2 No certificate Physicien: 8 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 28 No s efter death. I Director: After this c id in by the funeral dire 10 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred Certification: Injury at Work? or Attending 5 Pending investigation 1 Netural 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours To the Funeral C completaly filled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end piece, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year)

31

DHMH 16 Rav 6/95

State Registrar 31. Date filed (Month, Day, Year)
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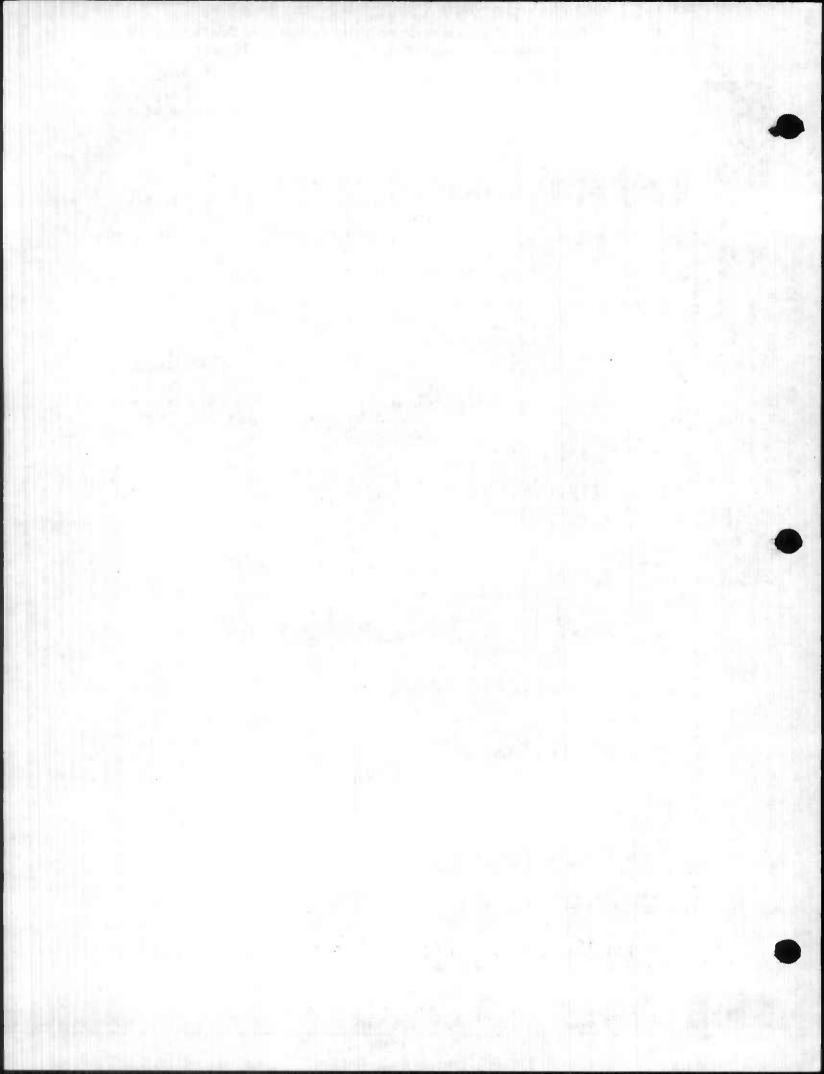
32. Registrer's Signeture

30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print)

B Sparks

ORIGINAL

9000 Franklin Square Drive Baltimore Maryland 21337

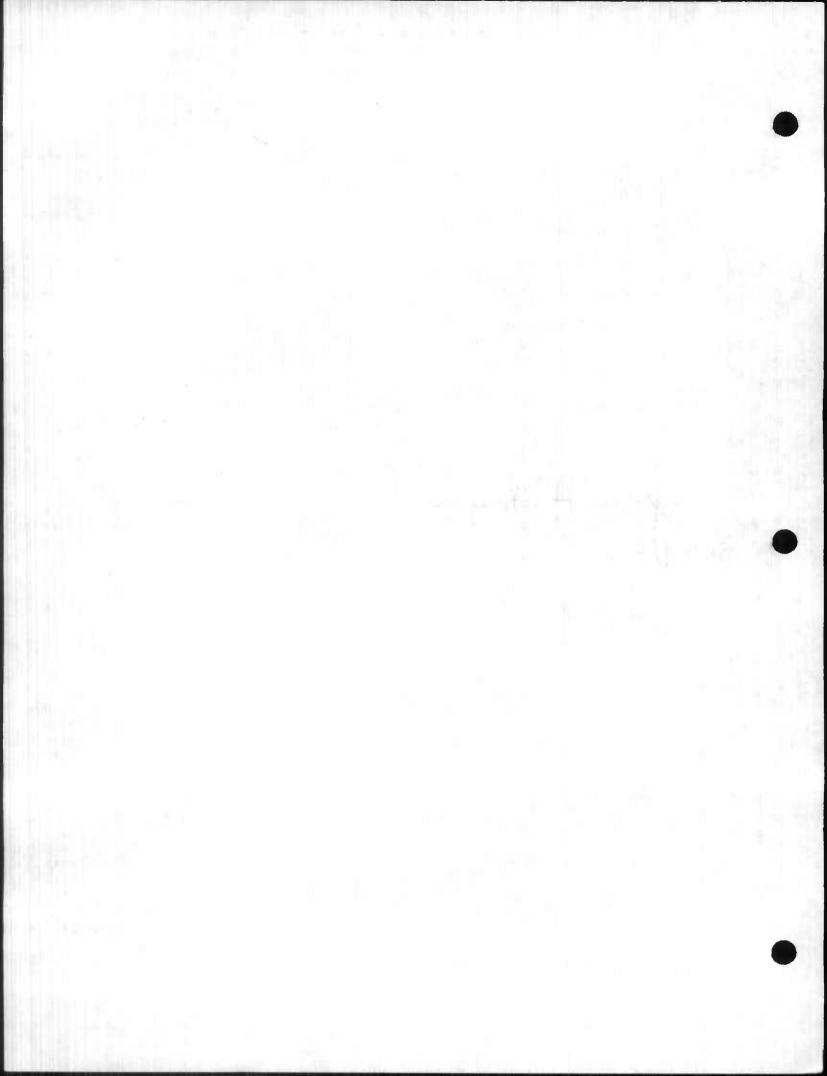


State of Maryland / Department of Health and Mental Hygiene (1)

	JC411D.LC			Certif	icate of	Death	F	leg. No.)	0004	
		1. Decedent's Name (First, Middle, La	st)				2. Date of Dea	th	Marra	3. Time of Death	
	Physician	TAYLOR		GAMI	BLE		Month Novembe	er 11, 2	Yaar 2000	12:03 P.M.	
	/Medical Examiner	4a Facility Name (If not institution, giv	e street and number)			4b. City, Town, or Lo	cation of Death	4c. County			
ľ		Johns Hopkins Ho	ospital			Baltimo	ore	N	I/A		
	Funeral Director	215-24-0704	ex 7. Age (In 7. Age	M	Under 1 Yea onths Days		8. Date of Birth (Month, Day 06 24	Birth Day, Year) 9.		olace (State or Foreign stry)	
	P .	Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Location	on				1	Od. Inside City Limits	
	lanyla dan			altimore						XXYes 2□No	
	vith the Mer to 284-1 at be mothed Director	MD NA 10e. Street and Number	De		Of, Zip Code			l 0g. Citizen of V	Vhat Cour	ntry?	
	with po a O		la Chusai			21213	and the	U.S		,	
	fler death v	1300 East Lan	12. Was Decedent Ever			Hispanic Origin? (Spo ban, Mexican, Puerto	ecity Yes or No-		e - Americ	an Indian,	
Maryland 21215-0020	0 0 0	XIX Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		es, specify Cu Yes 2X No		Rican, etc.)	Specify	Bla		
0	"natural", deal Exe leted by	15. Decedent's Ed	ducation	16a. Decedent	's Usual Occi	upation	ina	16b. Kind of Bu			
21	led within 72 ho ygjene. Ner then "neturn ft, the Wed call	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO	NOT use retir	e during most of work ed)	ing				
21	Hygien the three t	5th grade	na	Const	ructi	on Worker				on Co.	
Pu	Be vet	17. Father's Name (First, Middle, Last)				18. Mother's Name			10)		
yla	Men Men The	Tommie Gamble				1	Harrison				
Jar	0 0 0 0	19a. informant's Name/Relationship (at and Number or Run			_		
	Health em 27 other tr	Carrie Cousar-	Sister	3854] Ob. Place of Disposition		eld Ave.	Balti	nore M		1215	
100	8 ± 2 6 5	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cremeto	ory or other pi						
Baltimore,	2 2 2 2	4 ☐ Jonation 5 ☐ Other (Specif					11/17/	00 Owi	ngs	Mills, Mo	
Bal	permit. Pa Departmen Important any Injury and Ce.	21. Strutture of Funeral Service Liner	1000			H West					
	40240	germe +	· Stromps			bash Ave			Md	21215 Approximete	
1	Physician /Medical Examiner	Immediate Cause (Final disease or confidence of the condition resulting in deeth)	Arteriosc		rdiova				1	Interval Between Onset and Death	
	2 = 2	LEILE II DESC									
	physician and state that the burial-transit	Sequentially list conditions, if any, leading to immediate	Due Due	to (or as a consequen	ice of):						
90,	ificate be executing physician and as the burial-tra-	cause. Enter Underlying Cause (Diseese or injury									
68760,	physicies the but	that initiated events resulting in death) Last Due to (or as a consequence of):									
	E 0.6		d								
Вох	death cert e attendin od for use sician/N								1		
	as that the death cert igned by the attendin be detached for use by Physician/N	Part ii. Other significant conditions of	ontributing to death but not	t resulting in the under	rlying cause (given in Part I.				o the cause of death?	
0							10'	/88 2□No	3 Pro	bably 4X Unknown	
Records,	requires the sean signe hould be defected by							an sutopsy	24b. W	era autopsy findings	
000	_ 00		200 000					med?	co	railable prior to empletion of cause death?	
Re	The law ate has the page 2 s						Insp	ection 'es 25No		□Yes 2₽No	
=	certificate rector, pag	25. Was case referred to medical				26. Plece of Deet				3100 2010	
5		examiner? 1)∑ Yes 2 □ No	Hospital: 1 Inpatient	2 XER/Outpatient	3ELDOA	Other: 4 Nursing Ho			er (Sneci	(v)	
	Attending Physical death. Actor: After this by the funeral diffication: To	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	28c. In		28d. Describe I				
É		3 ☐ Suicide 6 ☐ Could not be determined	28e. Piace of Injury - building, etc. (Sp		factory, offic	9	281. Location (5 City or Tow	Street and Numb m, State)	oer or Run	al Route Number,	
	Mospital or At 124 hours aftar d Funeral Direct pelety filled in by edical Certiff		ysician: To the best of my niner: On the basis of exa- and manner stated.								
	W W	29b. Signature and title of certifier	1	,	29c. Lice	nse number		29d. Date signe			
	XX	stush	AVL	rots, MI	9	O.C.M.E.		Novembe	er 12	, 2000	
	41)	30. Name and address of person who	completed cause of deeth		•						
	9	Stephen S.	Radent.		Penn S	Street, Ba	Ltimore	, Maryla	and 2	1201	
	State	31. Date filed (Month, Day, Year)	32. Registrar's S	Hyriature /							

State Registrar

DHMH 16 Rev 6/95



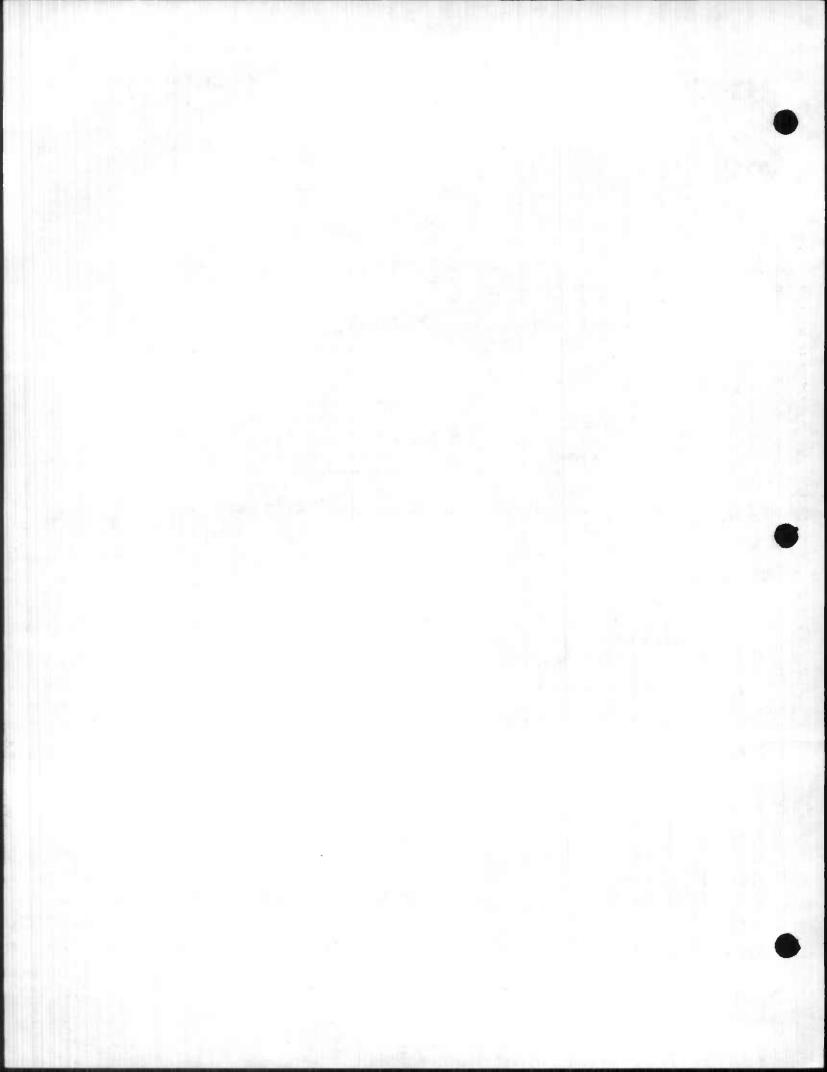
	4.4.	1. Decedent's Nama (First, Middla, La	st)		2. Data of D Month	Vanc	3. Tima of Death							
	Physician /Medical	Frederick Wi	lbert Ge	rmerot	h			NOVEME	BER 14	2000	2:40 AM			
Ä	Examiner	4a Facility Name (If not institution, give	a street and number)				4b. City, Town, o	or Location of Dea	th 4c. Count	y of Death				
		VA MARYLAND HEAL			at a Milk	nder 1 Year	PERRY F			CIL				
	Funeral Director	216-01-9453	M 2 F	6 (In yrs. last bi	Yrs. Mon			n. (Month, D	nn ay, Year) 1/1914	Cou	pplace (Stata or Foreig intry) Lto. MD			
	P A	Usual Residence of Decedent 10a. Stata 10b. County		10c. City, Tow	n or Location						10d. Inside City Limits			
	Many Many to to to	MD Harfo	nd	la	рра						1 Yas 2 No			
	vith the Mail or 28a-f all be notified	10e. Street and Number	1.0	00	101			10g. Citizen of	What Cou	intry?				
	death with the Maryland rine 23e or 28e-f show rinest be notified at	502 Echols Cou	rt			210	085		USA					
	free costs v freeze 234	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S.	13. Was D	ecadent of i specify Cut	Hispanic Origin? van, Mexican, Pu	(Specify Yes or Nerto Rican, atc.)		ce - Americk, Whita	ican Indian, . atc.			
020	by by	1 Nevar Married 2 Married 3 XWidowed 4 Divorced	1 🕅 Yas 2 📑 N If Yes, Give V Year or Dates:	If Yes, Give WMT 1 ☐ Yes 24			Specify:		Specil	y:	white			
2	ed within 72 ho tyglene. wr then "neturn it, fre theolea Completed	15. Decedent's Ed (Specify only highest gra		16a	Decedent's l	f work done	during most of w	vorking	16b. Kind of B	usiness/lr	ndustry			
121	mpl	Elementary/Secondary (0-12)	College (1-4or 5		'lifa. DO NO				Westerr	E10	otnic			
9	Hygle that it is a Co	12 Years 17. Fathar's Name (First, Middle, Last,	N/A	A	uditor	s Clei	+	ame (First, Middle			CUPIC			
Maryland 21215-0020	should be fill and Mental H armarked oth numatic evan	Gottfried Germero	th				Elizat	peth Mar	garet Ku	hn				
Mar		19a. Informent's Name/Ralationship (David Germeroth (**					Rural Routa Num		, State, Zi	ip Code)			
	1 and Health am 27 ther tr	20a. Mathod of Disposition	3011)		2 Eric		Court Jo	ppa, MD	21085 20c. Location	- City or T	own Stata			
more,	Pages national iny or o	1X Burial 2 ☐ Cremation 3 ☐		cemeta	ry, crematory	or other pla								
altir		4 Donation 5 Other (Specifical Signature of Funeral Service Licer		Meadov	vridge		ery ass of Facility	11/17/20	JUU Howa	ra C	Junty, MD			
B	permit. Departimontal	(1)	1		E 0	Lace	aha Fund	eral Home	е					
		23a. Part1. Enter tha disease, or com shock, or heart failure. List only	plications that coused	the death. Do	not enter the	750 Be	lair Rd	Kingsv:	ille, MD	210	87 Approximate			
Š)	Physician	shock, or heart failure. List only	one cause on each lin	10.						1	Interval Between Onset and Death			
ķ.	/Medical	Immediata Causa (Finat disease or condition	_ DEHYDRA	TON						1	25 Days			
	Examiner	resulting in death)		Due to (or as a	consequence	of):				1	25 Days			
	Z # Z		DIABETE	S MELLI	TUS TY	PE 1				i	Years			
	th certificate be executed tending physician and or use as the burist-transit an/Medical Examiner	Sequentially list conditions, if any, leading to immediate												
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1	34	KARMACHANDRA NATR				тнсл	E SVSTE	M, PERRY	POTNT.	MD 2	1902			
	State	31. Data filed (Month, Day, Year)		r's Signature	,			TI TIME						
	—	MOV 1 6 2000			9									

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

36385

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death JOHN HOWARD GRAY NOVEMBER 11, 2000 3:20pm 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth JOSEPH RICHEY HOSPICE BALTIMORE N/A If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) Months Days Hours 1X M 20 F 218-07-0603 Yrs 90 APRIL 1,1910 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits MD N/A BALTIMORE CITY 1 Tyres 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 710 SOUTH DECKER AVENUE 21224 U.S.A. Raca - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No If Yes, Give X 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Coilege (1-4or 5+) POLICEMAN BALTIMORE CITY 8 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) WILLIAM GRAY IDA HISLEY 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) MILLICENT L. GRAY-WIFE 710 S. DECKER AVENUE BALTIMORE, MARYLAND 21224 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stata Buriel 2 Cremetion 3 Removal from State Donation 5 Other (Specify) OAK LAWN CEMETERY 11/15/00 BALTIMORE, MARYLAND 21. Signatu 22. Name end Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVENUE BALTIMORE, MARYLAND 21224 23a. Pert1/Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final diseese or condition resulting in death) Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yss 2 No 24b. Were autopsy findings svailable prior to completion of cause of death? 24e. Was an autopsy performed? 1 Yes Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Spec ZIDA 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Netural 5 Pending Investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

and the burial-tran the attending physician thed for use as the buria ate has been signed by t page 2 should be detach this certificate has funeral After death. after death Director: / 3

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Certification:

Medical

29a. Certifier

(Check only

31. Dete filed (Month, Dey, Year)

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Funeral

Director

must be noti

Name 23s or

Maryland 21215-0020

Baltimore,

Pages 1 and 2 should be

Physician

/Medical Examiner

3:20 Pm

11,2000

JOVEM BER

Division of Vital Records, P.O. Box 68760 Hospital 24 hours a

> State Registrar

DHMH 16 Rev 6/95

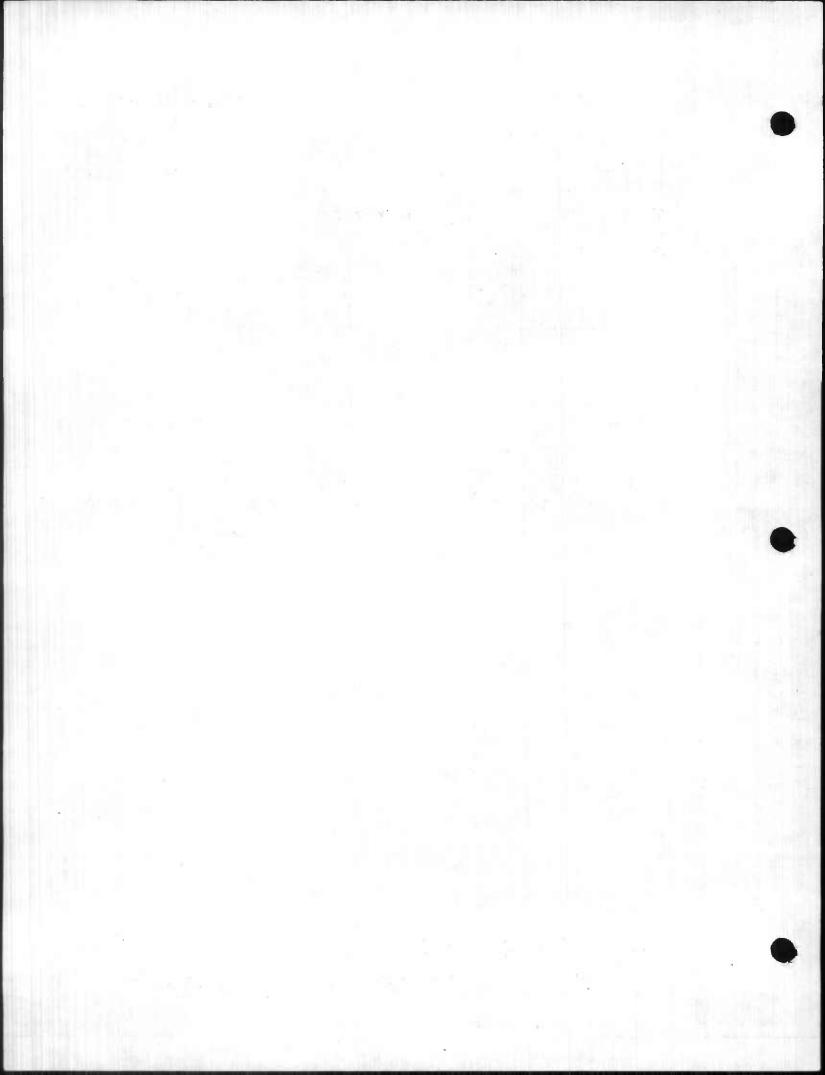
To the To the

t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29d. Dete signed (Month, Day, Year)

32. Registrar's Signetura



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death 2 8800 Erwin F. Hamel 6:20pm 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Maryland Masonic Homes Cockeysville Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) 9. Birthplace (Stata or Foraign 215-03-972 Usual Rasidance of Decedant 1 M 2 □ F Yrs eat 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits Maeyland 1 ☐ Yes 2 ② No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3048 14. Race - Amarican Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yas 2 No If Yes, Giva Yaar or Datas: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify:) hute Specify: () 3 Widowed 4 Divorced 18a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondery (0-12) Collega (1-4or 5+) MORRYISOR 12 17. Fethar's Nama (First, Middle, Last) 18. Mother's Nema (First, Middla, Maiden Surname) 19b. Mailing Addrass (Street and Number or Ruckl Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 20b. Place of Disposition (Nama of cematery, crematory or other place) 20a. Mathod of Disposition NOV / 20c. Location - City or Town, Stete 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 □ Donation 5 □ Other (Specify) emotes 22. Name and Addrass of Facility Esta Part. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata intarvai Between Onset and Death Alhemer's Dua to (or as a consequence of) Dua to (or as a consequence of): Due to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to complation of cause of death? 24a. Was en eutopsy performed? 2 No 1 ☐ Yas 1 ☐ Yes 2 No 28. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidence 8 Other (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Tima of 28d. Dascribe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Be 2

Funeral

Director

item 27 is marked other than "naturel", or items 23a or 28a-f show other treumstic event, the Modical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or itema 23a enty Injury or other treumatic event, the Medical Examiner must page.

Baltimore, Maryland 21215-0020

with the Maryland

physician and the burial-transit 88 usa for **page 2**

The law requires that the death certificeta be exec signed by the a Deed cartificate has Hospital or Attending Physician: 24 hours after death. Funeral Director: After this cartifice funaral director, To the Hospital or Atte within 24 hours after de To the Funeral Directo complately filled in by the

Division of Vital Records. P.O. Box 68760.

Examiner Physician/Medical P Completed Be 2 Certification:

Medical

State Registrar 30. Nama and address of person who complated causa of death (Itam 23a) (Type, Print)

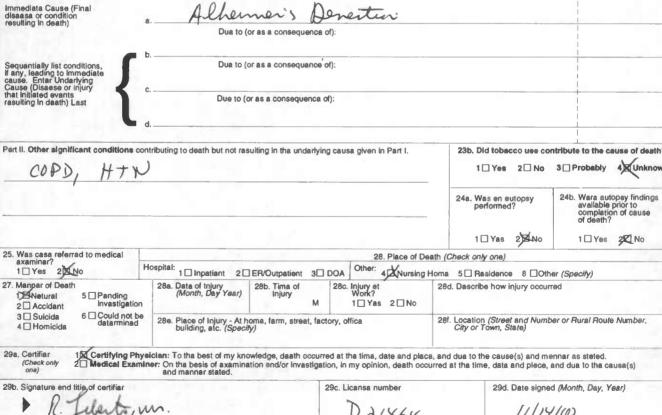
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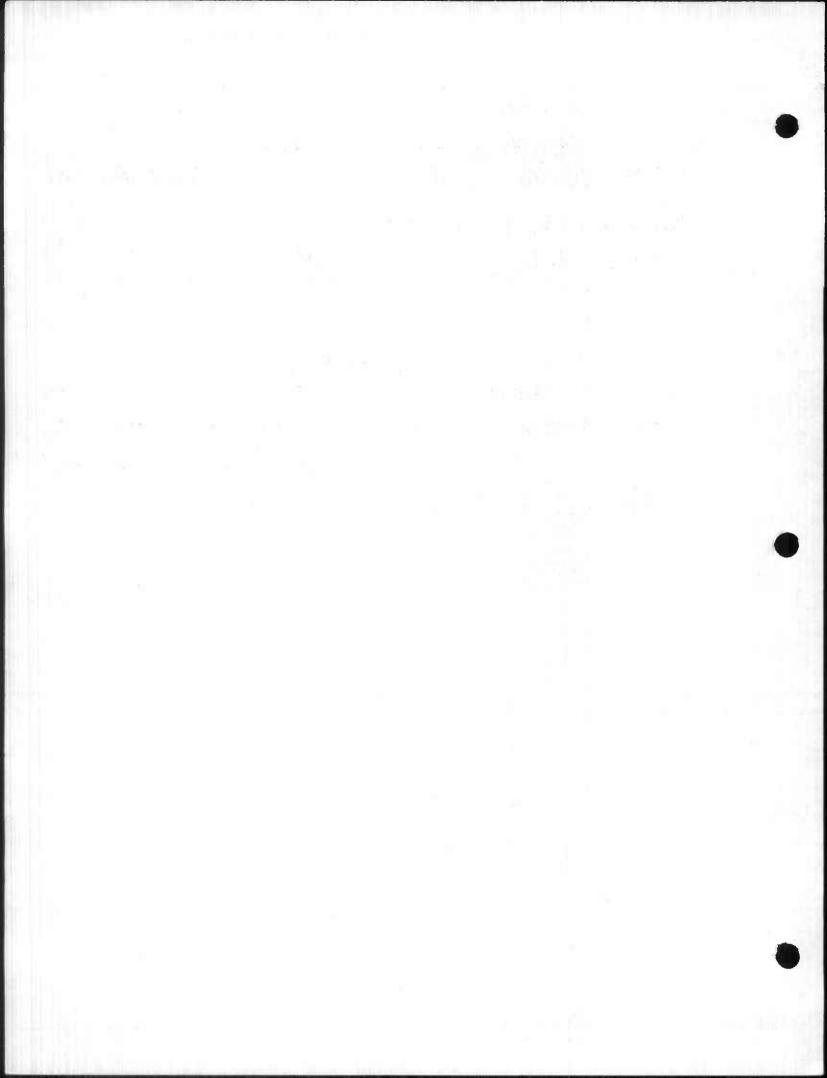
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32. Registrar's Signatura



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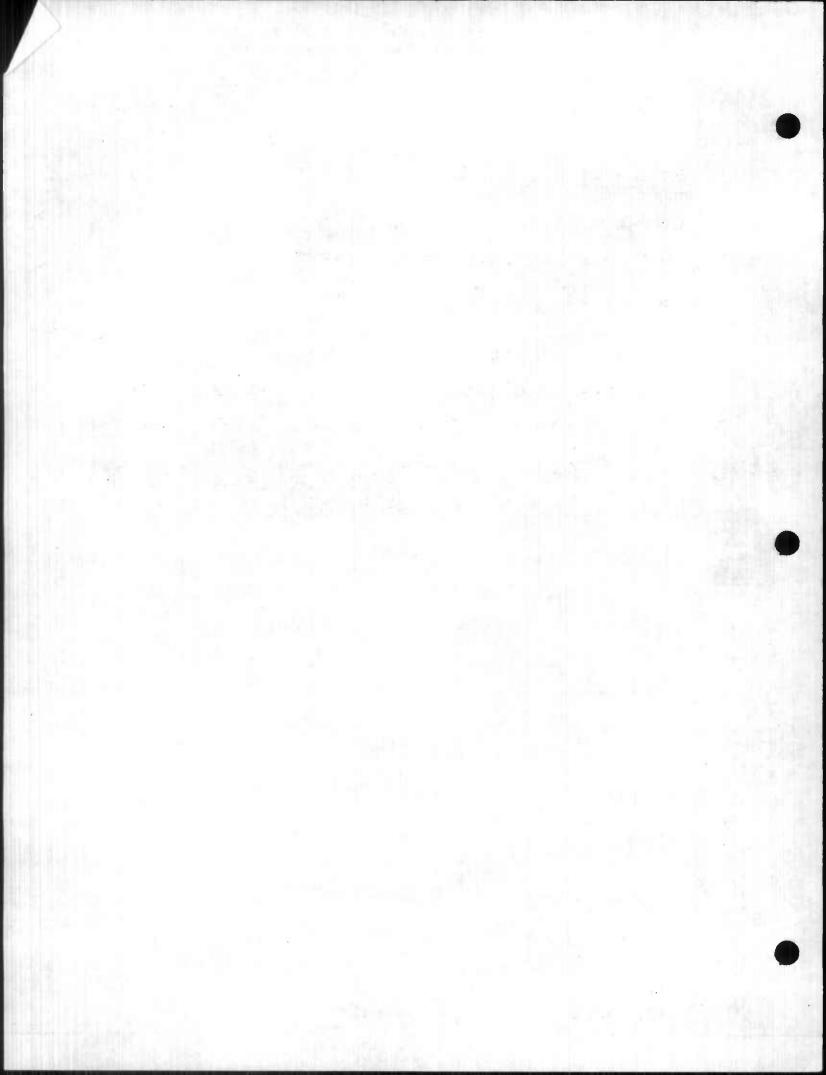


Heaps, Geneva

	State of Maryland / Department of Health and Certificate of Death	Reg. No.	0 36388
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Physician /Medica	I TE OFICE TEE HEADIN	NOVEMBER 15	2000 8:00AM
Examine	Ab City Town of	Location of Death 4c. Count	y of Death
	GREATER BALTIMORE MEDICAL CENTER TOWSON		TIMORE
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min	(Month, Day, Year)	Birthplace (State or Foreign Country)
Director	Usual Residence of Decedent	Nov-18, 1917	MARYLAND
A M	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
off) the Marylar or 28a-f show be notified at	MARAGO BATTIMORE GLEN ARM		1 ☐ Yes 250 No
or Starf.	10e. Sfreel and Number 10f. Zip Code	10g. Citizen of	What Country?
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Ore - the r	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Nov-18 20c. Location	- City or Town, State
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/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. DISSEMINATED COAG	ULOPATHY	. 10
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Broth the total	29b. Signature and title of certifier 29c. License number	29d. Date aign	ed (Month, Day, Year)
NVA	Sompath Pearade D 16163	11/13	,,00
LDV/	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	FURTER	40816
	DR. SOMPALH PEARADE 6701 NORTH CHAR	RLUSTRUST	Towson Mo.
State	NOV 1 6 2000 Security Signature Sports		
Registrar	140 A T 0 5000 12 12 1 1000		915-1017-7-11

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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

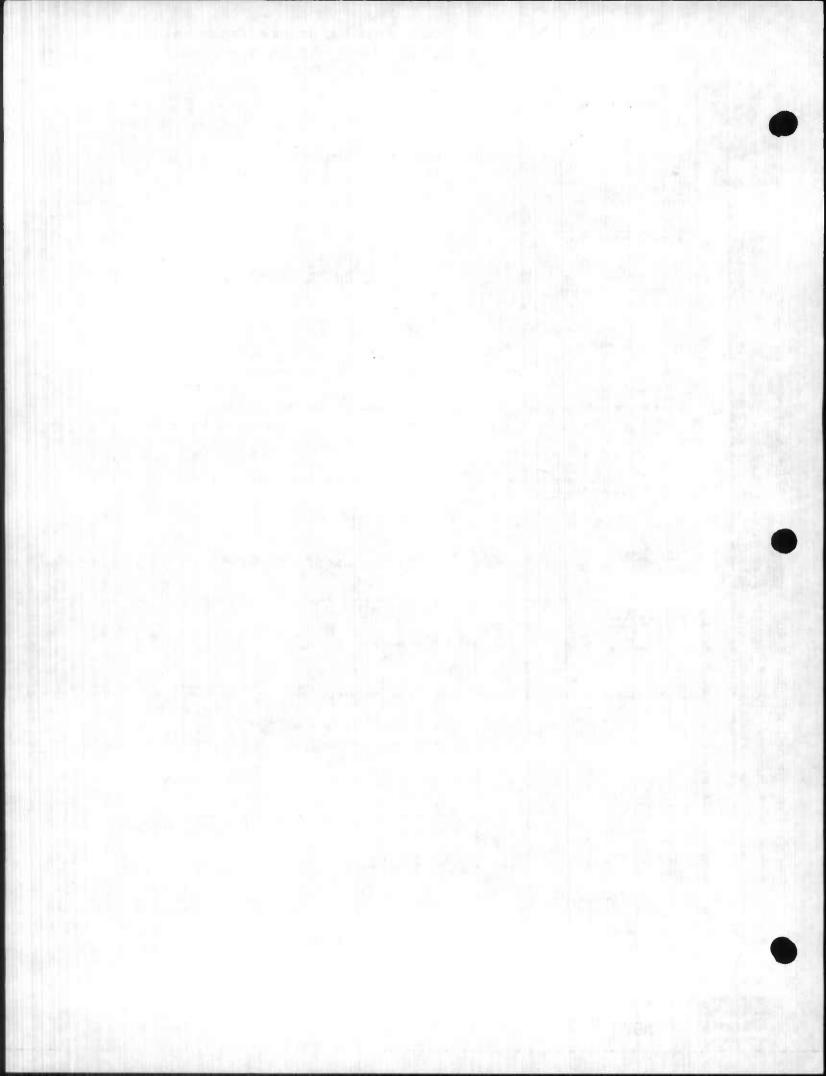
Certificate of Death

Bea No.

2. Date of Death 1. Decedent's Nema (First, Middle, Last) 3. Time of Death Month November 12, 2000 **Physician** Myrtle V. Heckler 2:15 AM /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Health of Laurel Prince Georges Laurel 5. Social Security Number If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth Near) 10/10/1912 Birthpleca (State or Foreign Country)

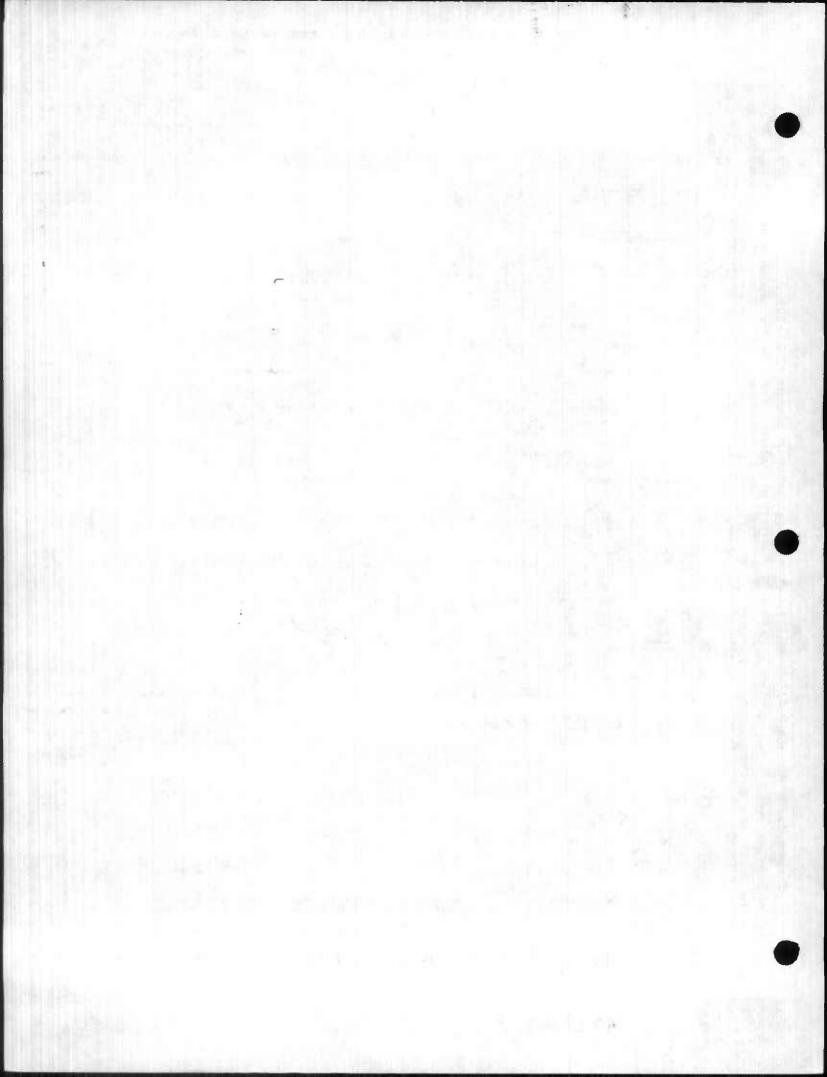
MD 7. Age (In yrs. last birthday) **Funeral** 1 M XXE Days Hours 88 218-05-7726 Yrs. Director Usuel Residence of Decedent 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Prince Georges Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ĕ 238 14200 Laurel Park Drive 20707 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas ঐ Ď No If Yes, Give Yeer or Detes: Or Reme 14. Race - American Indian, Bleck, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 11. Merital Stetus 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 □ Yes X No Specify white Specify. Aq XX Widowed 4 □ Divorced Completed 15. Decedent'e Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cake Decorator Bakery 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) permit. Pages 1 and 2 should be fis Department of Health and Mental Hi Important: If them 27 is merked oth any injury or other traumatic even obtain. John Frizebee Claira Montgomery 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Carolyn M. Jones 716 Cotter Road, Glen Burnie, MD 21061 20b. Piece of Disposition (Name of 20c. Location - City or Town, Stata 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burlal 2 XX remation 3 ☐ Removel from Stete Metro Crematory 11/13 Baltimore, MD 4 Donetion 5 ☐ Other (Specify) 22. Nama and Address of Facility FINK FUNERAL HOME, PA Kelly Gragory 426 Crain Hwy., SW, Glen Burnie, MD 21061 23a. Part Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock or most launce. Let only one ceuse on each line. Approximate Intervel Between Onset and Deeth **Physician** alberdentin Veres Occare Immediate Ceuse (Finel disease or condition resulting in death) /Medical Examiner Due to (or es a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence of): P.O. Box 68760. Dua to (or as a consequence of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown Records. Certification: To Be Completed by 24b. Were autopsy findings 24a. Wes en autopsy performed? funeral director, page 2 should eveilable prior to completion of cause of death? 1 Yas 2 No 1 ☐ Yes 2 ☐ No of Vital Hospital or Attending Physician: 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpetient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Menner of Deet 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Division 1 Watural 5 Pending investigation 1 Yes 2 No 2 Accident after death Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide 24 hours a Funeral stell filled 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner steted. edical 29a. Certifier To the 29c. License number 036716 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certified Ander feudato 30. Neme and address of person who completed ceuse of deeth (Item 23a) (Type, Print) Cherry lone loure (, ME 2000) (31) Hadrew Fundout 14.0. 31. Deta filed (Month, Dey, Year) 32. Registrer's Signature State Registrar NOV 1 6 2000 **DHMH 16 Rev 6/95**



State of Maryland / Department of Health and Mental Hygiene 00 36390

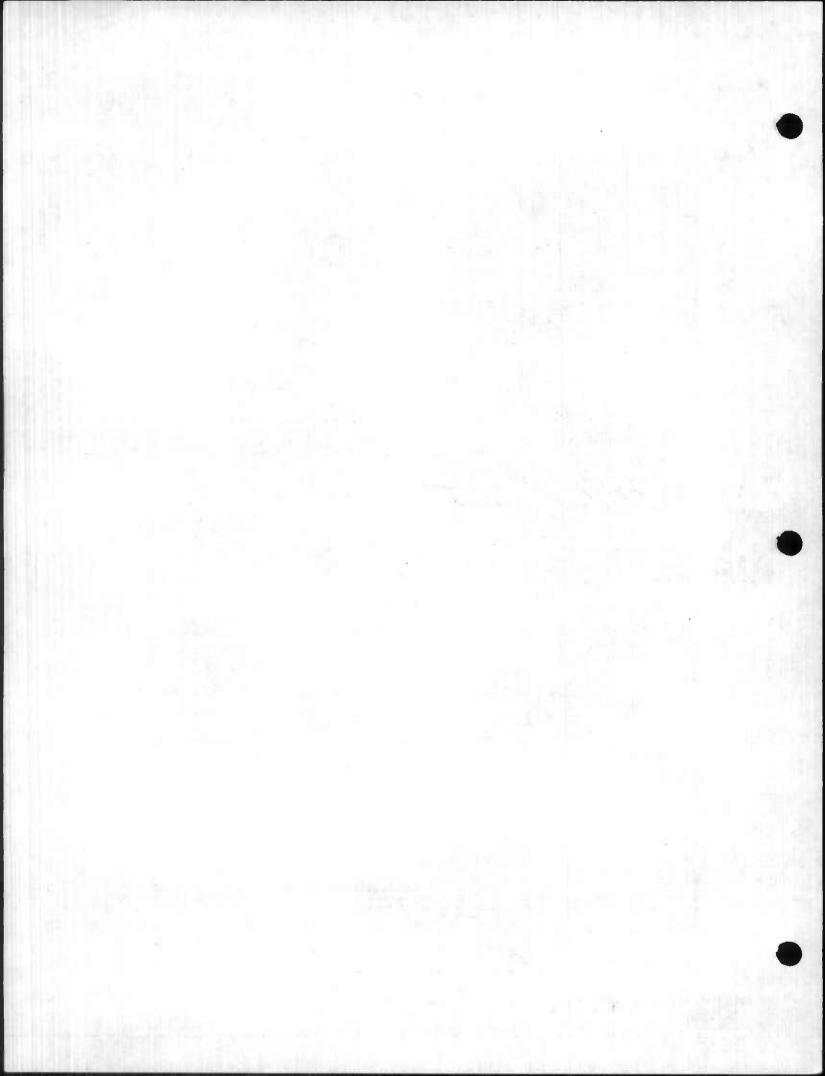
	Certificate of Death	R	leg. No.									
	Decedent's Name (First, Middle, Last)	2. Data of Dea Month		Year 3. Ti	ime of Death							
Physician /Medical	Elizabeth Hofmann		2, 2000		:30AM							
Examiner		r Location of Death										
86		imore	N/									
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 □ ▼ 7. Age (In yrs. last birthday) Months Days Hours Mi		Year)	9. Birthplace (S Country)	State or Foreign							
Director	212-12-1011	July 1	5,1921	Maryl	and							
2	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Ins	side City Limits							
faryi ed a	MD N/A Baltimore				Yes 2□ No							
with the Many a or 28a-1 sh be notified.	10e. Street and Number 10f. Zip Code		log. Citizen of Wh	nat Country?								
D D D			og. Onizon of vin									
earth mas 23	3939 Roland Avenue Apt. 611 21211 11. Marital Status 12. Was Decedent Ever In U.S. 13. Was Decadant of Hispanic Origin?		14. Race	- Amarican indi	ian.							
Pun Pun	11. Marital Status 12. Was Decedent Ever In U,S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes ※ ★★No	arto Rican, etc.)	Black,	Whita, etc.								
DZC In an all	If Yes, Give 1 ☐ Yas 2 ☑ No Specify: Year or Datas:		Specify:	whi	te							
De sale	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Busi	iness/industry								
Please Pelo	(Specify only highast grada complated) (Give kind of work done during most of work and of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work d	orking										
1 2121 led within tygiens. We then t, the Me	9 Assembler		Elect	ronic	S							
Maryland 21215-0020 d.2 should be filed within 72 hours at th and Mental Hygiene. 7 is marked other than "natural", or traumatic event, the Medical Exam To Be Completed by I	17. Father's Name (First, Middle, Last) 18. Mother's N	ame (First, Middle,	Maiden Surname))								
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N STATE	William Hofmann, Jr. Son 13 Valley Road Ab	perdeen,	Maryla	and 21	001							
op of the	20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - C	ity or Town, St	ate							
altimore mit Pages t partment of H portant: if Ner y Injury or oth	1 Burial 200 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify) Baltimore-Washington	11/15/0	0 Laure	el, MA	ryland							
all posts	21. Signature of Funeral Sarvice Lease 22. Name and Address of Facility											
m 88588	Burgee-Henss-Se 3631 Falls Road	eitz Fun	eral Ho	ome, I	nc.							
Name and Address of the Owner, where	23a. Part1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or hear it lura. List only one cause on each line.	ac or respiratory an	rast,	Appro	oximate							
Physician	Shock, or near fatura. List only die cause on each line.				ral Between it and Death							
/Medical	Immediate Cause (Final disease or condition resulting in death) a. Chronic obstructive pulmorary disease											
Examiner	resulting in death) Due to (or as a consequence ot):	2700	9 00	26×3 6								
P = 2												
60, Consider and sician and burial-transit	Sequentially list conditions, if any, leading to immediate											
	Ceuse. Enter Underlying Cause (Disease or Injury											
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the de sched in y the sached in y sich	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did to	obacco use conti	ributs to the co	ause of death?							
that the ed by the deteche	hypertension	1 🗆 Y	/88 2□ No 3	3 Probably	4) Unknown							
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Rec e law has b ye 2 si				of death?								
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f Vital Ryysician: The I	examinar?	eath (Check only or	ne)									
of Vital Records, Physician: The law requires the this certificate has been signe and director, page 2 should be real director, page 2 should be contiled by the completed y the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by the complete by	1 Yes 2 No Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing	Home 5 Resid	lence 6 Other	(Specify)								
ding P. After t	27. Manner of Death 1 Matural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work?	28d. Describe h	ow Injury occurred	d								
Division or Attending after death. Director: After d in by tha tune ertification	2 Accident investigation M 1 Yes 2 No											
	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	281. Location (S City or Tow	Street and Number m, State)	r or Rural Route	e Number,							
O les les o			AT MISIL									
The Hospital of 24 hours a refuneral is plately filled edical Ce	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pla (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death oc				ause(s)							
Divi	one) and manner stated.											
5 1 1 5 0 S	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)										
, 1	Rodney 1800ks m. n. 043636		love m t	pe la	1,2000							
4	30. Nama and address of person who completed ceuse of death (Item 23a) (Type, Print)				1							
	Rodney Brooks, MD Belair Road Family Health	Center 1	Baltimo	re, MD	21213							
State	31. Date filed (Month, Day, Year) 32. Registrar's Signatura											



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 3639

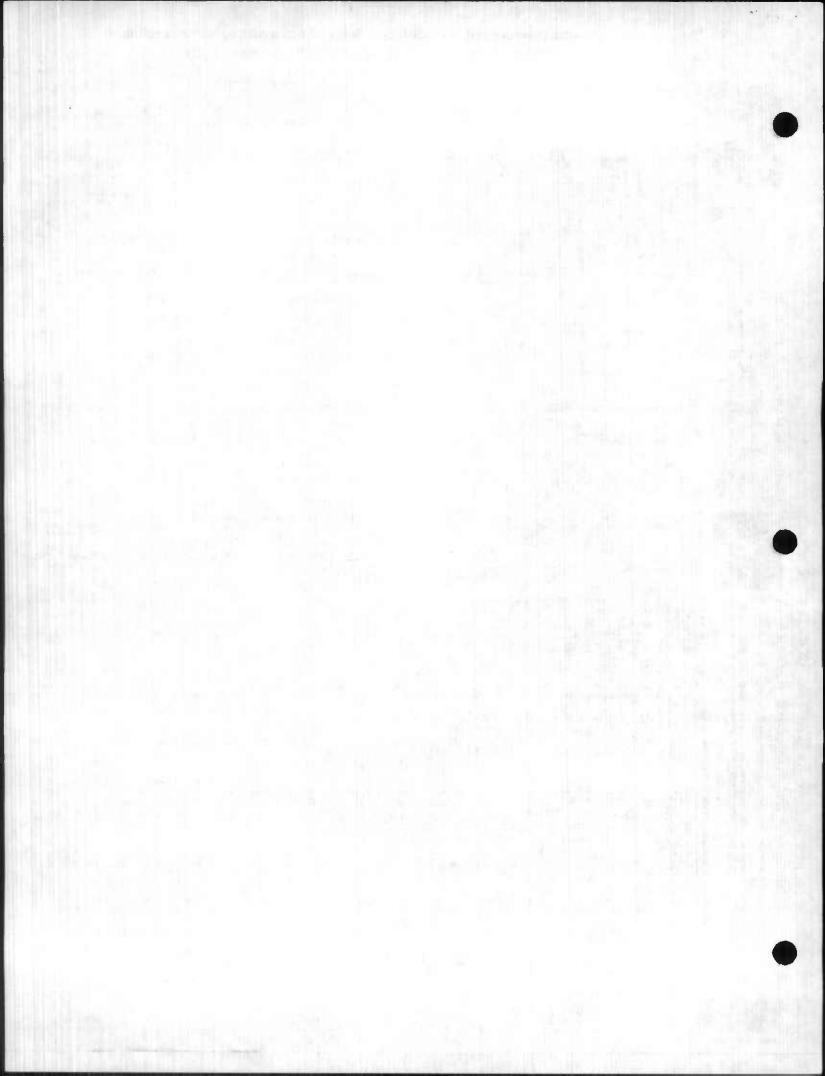
			Cen	ificate of	Death		Reg. No.				
Physician /Medical	1. Decedent's Name (First, Middle, La	James	D. Horn			2. Date of Do		Year 3. Time of Death 6:00 pm			
Examiner	4a Facility Name (If not institution, giv Union Memo	rial Hosp	ital			or Location of Dear imore	N/A	A			
Funeral Director		Sex. 7. Age (1451 M 2□ F 77	In yrs. last birthday) Yrs.	Months Days	If Under 24 Hours	Hrs. 8. Dete of Bi Min. (Month, D	rth ey Year) 19, 1923	9. Birthplace (State or Foreign Country) 3. Maryland			
fled at tor	Usual Residence of Decedent 10a. State 10b. County MD	N/A	Oc. City, Town or Loca		ltimor	·e		10d. Inside City Limits MYSes 2 □ No			
23s or 28s-f sho ant be notified at al Director	10e. Street and Number 4 3 1	4 Falls R	d.	10f. Zip Code	212	11	10g. Citizen of W	hat Country?			
st, or liens 23s Examinar must 3 by Funeral I	11. Marital Status 1 Never Married 2X14/Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? XIXYes 2 □ No If Yes, Give 1 Yeer or Dates:	II.	as Decedent of H Yes, specify Cub	an, Mexican, F	? (Specify Yes or No Puerto Rican, etc.)	Black	- American Indian, , White, etc. White			
event, the Medical. Be Completed	15. Decedent's Elementary/Secondary (0-12)		16a. Decede (Give ki life. Do	ont's Usual Occup ind of work done ONOT use retire ROOTE1	petion during most of d)	working	16b. Kind of Bus				
	17. Fether's Neme (First, Middle, Last,	Dell Ho	rn			Name (First, Middle garet Jo)			
	19a. Informant's Name/Relationship (Julia Horn (Wi	Type, Print) fe)		Address (Street Falls		Balto, I					
ant: If Rem 27 is ury or other trau	20a. Method of Disposition 1 Disposition 2 Cremation 3 Carry Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Con		20b. Place of Disposi cometery, creme Lakevier	ition (Neme of etory or other ple W MEMO1	rial	Date 11/17		City or Town, State Ville, MD			
sician	21. Signature of Funeral Service Licer	Carpen	Bu:	Name end Addre rgee-He 31 Fall	enss-S Ls Rd.	eitz Fur Balto	neral Ho	ome, Inc.			
	23a. Part1. Enter the disease, or com shock, or heart failure. List only						arrest,	Approximate Interval Between Onset and Death			
niner	disease or condition resulting in death)	a. FND	STAGE va to (or as a consequent		npitys	EMA		SYEARS			
Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Entar Undartying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):										
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State of Maryland / Department of Health and Mental Hygien

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No		0	U	U	V	7

						Ce	rtificate	of I	Death			Reg. No.			000	60
			ame (First, Middle	, Last)							2. Date of D				3. Time of De	eath
	Physician		Margar	et Chell H	loran						Month Nov	Day	2000	ear	11.02	DAA
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0 3	d Man	-	Name/Relations			19b Mail	ing Address (S								Code)	
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9		23a. Part1. Ent	the disease, or	complications that ca	used the deet								101.65	. 1	Approximate	
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BO	th carrier or us			-	12.00									Î		
1.	The law requires that the death cate has been signed by the attence page 2 should be deteched for us	Part II. Other sig	nificant conditio	ns contributing to dea	ith but not res	ulting in the I	underlying caus	se giv	en in Part	I.	23b. Dio	tobacco	use contr	ibute to t	the cause of c	death?
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Vital	Physician: The this certificate ral director, page 7.70 Ref.		ferred to medice i	Hospitai:				Oth	mr.		th (Check only				16	
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S no	After funer	27. Menner of De	eetn 5 ☐ Pendin	28a. Date of (Month)	, Day Year)	28b. Time of Injury		. Injur			28d. Describe	now injury	y occurred	,	0	
0 0	Attending or death. octor: Afte by the func	2 Accident					M	10	Yes 2□	No						
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	splt hour hour y fill	29e. Certifier		g Physician: To the b												
	To the Hospital o within 24 hours af To the Funeral Di completely filled in	(Check only one)	2 Medical I	Examiner: On the bas	sis of examina or stated	tion and/or ir	nvestigation, in	my o	pinion, de	ath occur	rred at the time	, dete and	place, sn	u due to t	me ceuse(s)	
	ro the comp		nci sitio di prifitior	11	110		29c. L	icens	e number				e signed (
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	0 1	1/U - 14	onth Courter	7 000	giotro della	201	14.0	1		- C	-1 , ,,	~~~	200		-	-
	State	31. Date tiled (M	onth, Day, Xear)	1 6 2000	gistrar Signa	Nure	A	Ko	a de	1						
	Registrar	1000			10		/ /	9	and the same							



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedant's Nama (First Middle Last) 2. Data of Death 3. Time of Death Month 500 p.M **Physician** HARBIN 0000 ANDREW /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number, Examiner GENERAL COLUMBIA HOWARD HOSPITAL GOUNTY HOWARD 7. Aga (In yrs. last birthday) | Hundar 1 Yaar | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Social Security Number Birthplaca (Stata or Foreign Country) **Funeral** 1□_{XM} 2□ F Months Days Hours Yrs 89 218-14-5857 Director Nov 14, 1910 Tennessee Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show 1 ☐ Yas 2 🛛 No Director Maryland Howard Ellicott City 10e. Street and Number 10g. Citizan of What Country? 10f. Zip Code "natural", or items 23s or 21042 U.S.A 9736 Old Frederick Road Funeral 12. Was Decedant Evar in U.S. Armed Forcas? 13. Was Decedent of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Baca - American Indian. 11. Marital Status Black, Whita, atc. 1 ☐ Yas 2 ☐ No If Yas, Giva 1 ☐ Navar Married 2 ☐ Married 1 Yas 2 No Specify: Specify: White P 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Contracting filed with Hygiene. Farmer 12 18. Mothar's Nama (First, Middla, Maidan Surname) 17. Fathar's Nama (First, Middla, Last) Be 12 should be 1 h and Mental h is marked of Cowan Minotia Phillip Harbin 2 permit. Pages 1 and 2 sh. Department of Health and Important: If New 27 is me. any Injury or 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) 9736 Old Frederick Road Ellicott City, Maryland 21042 Mrs. Martha A. Harbin 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cramation 3 □ Ramoval from State 11/16/00 Marriottsville, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) Crest Lawn Memorial Gardens 21. Signatura of Funaral Sarvice Licensaa 22. Nama and Addrass of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 MOIIIS 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in death) PULMONARY EDEMA Examiner Dua to (or as a consequanca of) Examine sician end burial-trans Sequentially list conditions, if any, laading to immadiate causa. Enter Underlying Cause (Diseasa or injury that initiated events resulting in death) Last Dua to (or as a consequence of): attending physician for usa as the buria PNEUMONIA Physician/Medical Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. deteched the 1 Yes 2 No 3 Probably 4 Unknown signed by by 2 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

has

this certificate

After

3

edicai

after death Director:

To the Hospital of within 24 hours at To the Funeral Di completaly filled in

Baltimore, Maryland 21215-0020

68760

Box

P.O.

Division of Vital Records.

Completed page Be 10 Certification:

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicida

29b. Sometime and titla of certified

25. Was casa ratarrad to medical axaminar? Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 27. Manner of Death 28b. Tima of Injury 1 Natural

28a. Data of Injury (Month, Day Year) 5 Panding invastigation 6 Could not be determined

28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify)

26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 28c. Injury at Work? 28d. Dascribe how injury occurred

1 Yes 2 No 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

1 Yas 2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the tima, data and place, and due to the cause(s) and mannar stated.

TU, M. 1

29c. Licansa number

29d. Data signed (Month, Day, Year)

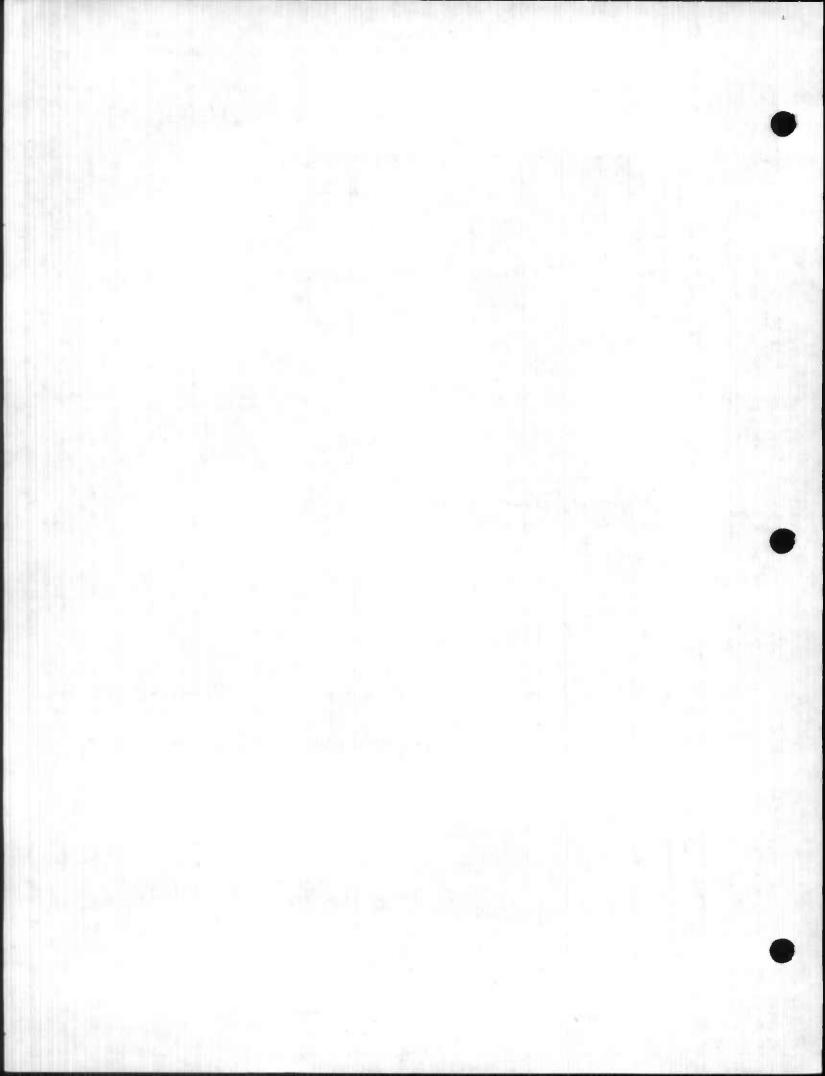
1 □ Yas 2 □ No

30. Name and address of person who complated causa of death (Item 23a) (Type, Print) MCCARdHY TH, M.D.

KOBERT 32. Registrar's Signatura 31. Data filed (Month, Day, Year) NON ZERBAR

5900 CEDAR. LANE COLUMBIA MD 21044

Registrar



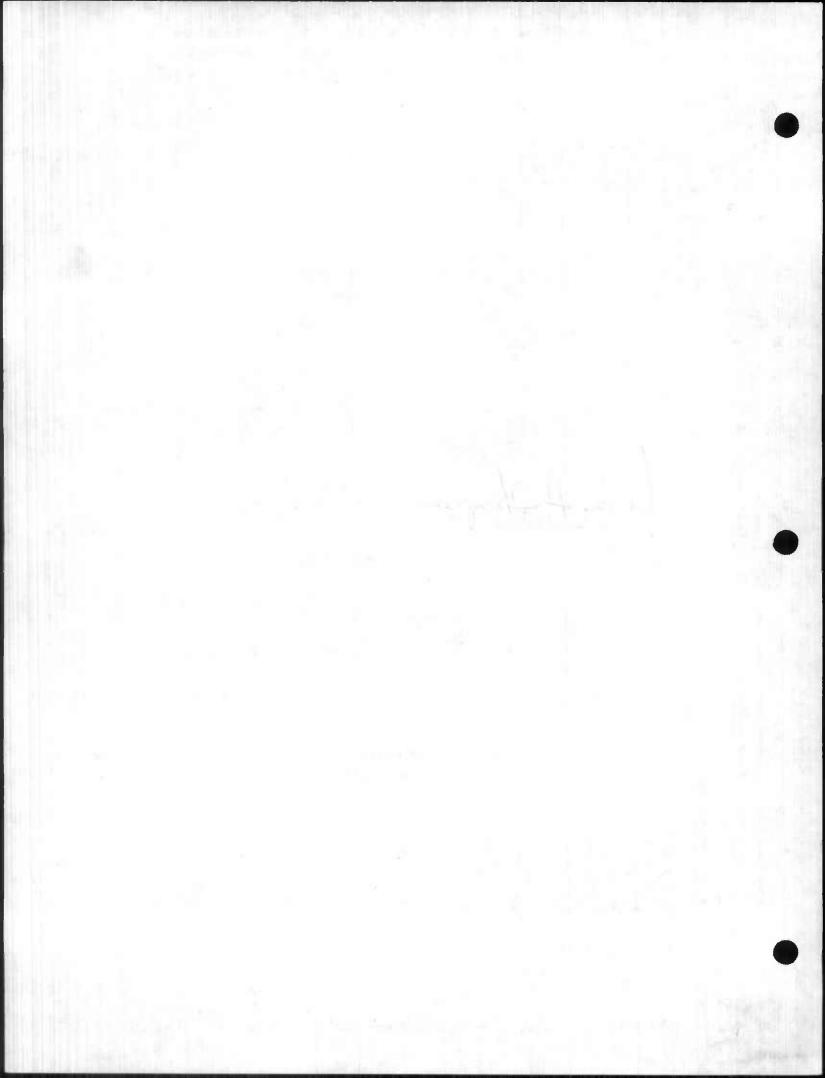
00-6439-005 jhm JAMES HURBERT HOL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 36394

LA	ND						Ce	rtific	ate of	Death			Reg. No.			24
	Physician	_	1. Decedent's Name (First, Mic	idie, La	James	н.	Hollan	d II	ī			2. Data of De Month	Day	Year		e of Death
7	/Medical		4a Facility Name (If not institut	ion, aiv			TIOT TUIT	u 11	-	4b. City, To	own, or L	NOVEME		2000 nty of Death	05	11 AM
	Examiner		308 HENDRICH										BAL	TIMORE		
	Funeral Director		5. Social Security Number 213-86-0593	6. 5	M 2□F	7. Age (In yrs 27	. last birthday, Yrs.	Mont	der 1 Year hs Days		Min.	8. Date of Bir (Month, Da 8-20-	th 19. Year) 1973	9. Birthi	ntry)	nte or Foreign
	B	-	Usual Rasidence of Decedant 10a. State 10b. Cour	itv		10c. C	ity. Town or L	ocation							IOd. fnsic	le City Limits
	with the Marylar a or 28s-f show the notified at Director		110	ilto		01	wings N	_							10	Yes 2/CYNo
	23a or 2 Mart be Dr		31 Enchanted	Hil	1 Road			2	Zip Code 1117				U S	Α		
21215-0020	art of them 234 Examiner must by Funeral	-	11. Marital Status 1 Never Married 2 M 3 Widowed 4 Divorce		12. Was Deci Armed Fo 1 Ves If Yes, Gir Year or D	2 X No	J,S. 13.		cedent of pecify Cul			ecify Yes or No Rican, atc.)		Race - Amaric Black, White, city: B1	etc.	n,
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lan	Mental H Mental H inhed off its even To Be	1	James H. Hol									ne Robi				
Maryland	and 2 shoul falls and Mo 27 is ment or traument		19a. Informant's Name/Ralatio	_		V 1	19b. Maile	ng Addi	ess (Stree			ral Route Numb		wn, State, Zij	Coda)	
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nore	Deallimore permit Pages 1 - Department of He important; if Nen any injury or oth odice.	1	20a. Mathod of Disposition 1 Dural 2 Cramalio				Place of Disponentary, cre				1 1	Date -18-00		on - City or To	own, Stat	е
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	he law e has t age 2 a											Ox	Yes 2 N		Α,	2 No
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>	Physician: this certific ral director,		examiner? 1X Yes 2 No		Hospital:	Inpatient 2	☐ ER/Outpatie	nt 3[DOA O	Whoe		ome 5□Ras		Other (Speci	ify)	-
1 0	Aling Ph. h. After thi funeral		27. Manner of Death 1 □ Natural 5 □ Pen	dina	28a. Data	of Injury th, (Day Year)	28b. Time of	of	28c. Inj W	ury at	,	28d. Dascribe	how injury oc	curred		
10	Attending or death. ector: Afte by the fune		2 Accident Inva	stigatio	1/1/12	100	OSI	М		☐ Yes 2	No	July	ed	8401		
Division	is or Attending P is after death. In Director: After ted in by the funers Certification:		3 ☐ Suicida 6 ☐ Cou data	mined	Zom. Flace	of Injury · At I	home, farm, si	reet, fac	tory, office	9		281. Location	Streat and Nu wn, State)	mber or Ru	al Route	Number,
	montal or Attending in hours after death. moral Director: After Willed in by the fune						STR	et	7			738 H	endrice	Esoul	N.	
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	1		V/ ctorlays) OCME										NOVEM	BER 12	2, 20	000
	NA	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)														
	019		TRARAN	16	ocker!	(10)			Str	eet E	tal+÷	more, M	larrel an	A 2120	11	
	State		31. Dale filed (Month, Day, Ye	ar)	32. F	legistrar's Sign		- (111)		July E	ALL.L.	more, r	KILY TOU	M-2121	1	
	Registrar		11011 # 0 0000		6.	6	10	2.11	1							

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day Walter Howard, James 14,2000 November 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Hospital Nion memorial If Under 1 Yaar | Months Days If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day) 5. Social Security Number 6 Sax Birthplaca (Stata or Foreign Country) 10 M 20 F Hours Min 60 Yrs. 219-26-2710 21/1940 MA Usual Rasidence of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 PYas 2 No Baltimore MD 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 618 USA 21218 umbar ton Avenue 12. Was Decedent Ever in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Raca - Amarican Indian, Bleck, White, atc. 11. Merifal Stafus 1 Yas 2 No If Yas, Give Yaar or Datas: 1 Nevar Married 2 Married 1□ Yas 2₺No Specify. Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Spacify only highast grada complated) 16h Kind of Rusinass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Construction Laborer 6 17. Fether's Nema (First, Middla, Last) 18. Mother's Nama (First, Middla, Meidan Sumame, Hattie James W. Howard) Howard 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Catherine Howard Ba It. WIFE Dumbarton 20a. Mathod of Disposition 20b. Plece of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, State Data 1 ☐ Burial 2 D Cramation 3 ☐ Removal from State Green Mount Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility Hari P. (105 e 21. Signature of Funeral Sarvice Licenta Funeral Senvice 5+. 709 Tessier 21201-1925 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Batween Onsat and Daath Immedieta Causa (Final disaasa or condition resulting In daath) reumonia ancreatitis Dua to (or es a consequance of) Kenal 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara sutopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 Yas 2 No 26. Place of Death (Check only one) Hospital: 5 Rasidence 8 Othar (Specify)

Physician /Medical Examiner

Physician/Medical Examir

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To

Certification:

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Physician

/Medical

Examiner

Director

Funeral

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Completed

Funeral

Director

item 27 is marked other than "natural", or hams 23s or 28s-f show other traumatic avant, the Medical Examinar must be notified at

Hygiene.

should be ind Mental

permit. Pages 1 and 2 should be 1 Department of Health and Mental P Important: if item 27 is marked off any injury or other treumatic avar

72 hours after death

Saltimore, Maryland 21215-0036

68760

Vital Records,

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certificate has

After Attending

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Sequentially list conditions, if any, leading to immadiata cause. Entar Undarlying Cause (Disease or Injury that initiated events resulting in death) Last

25. Was casa rafarred to medical examinar?

1 Inpatiant 2 ER/Outpatient 3 DOA

1 Yas 2 No

28b. Tima of

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

Other: 4 Nursing Home

27. Manpar of Death Natural

2 Accident

3 Suicide

4 | Homicida

5 Panding invastigation

28c. Injury at Work? 1 Yas 2 No

28d. Describe how injury occurred

29a. Certifier

1/2/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and titla of certifiar

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stete)

6 Could not be

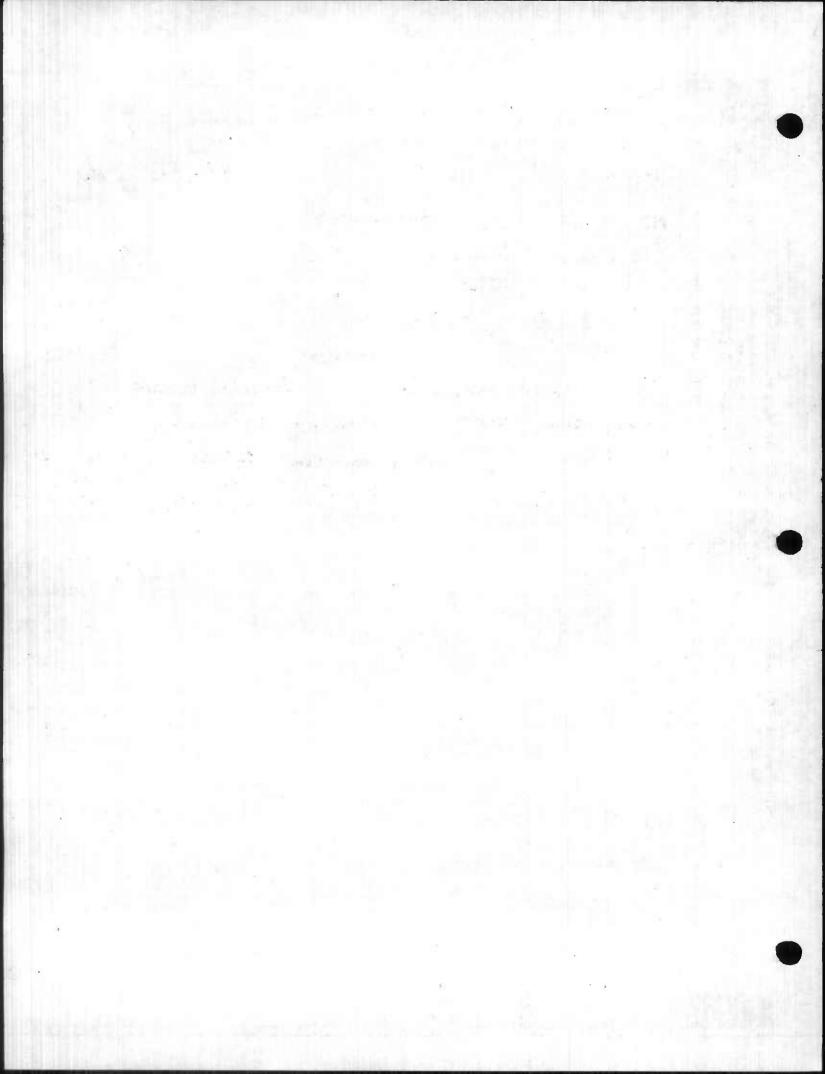
30. Nama and address of person who completed causa of death (Item 23a) (Type, Print)

31. Data filed (Month, Day, Year)

201 E. Universitu 32. Registrar's Signature

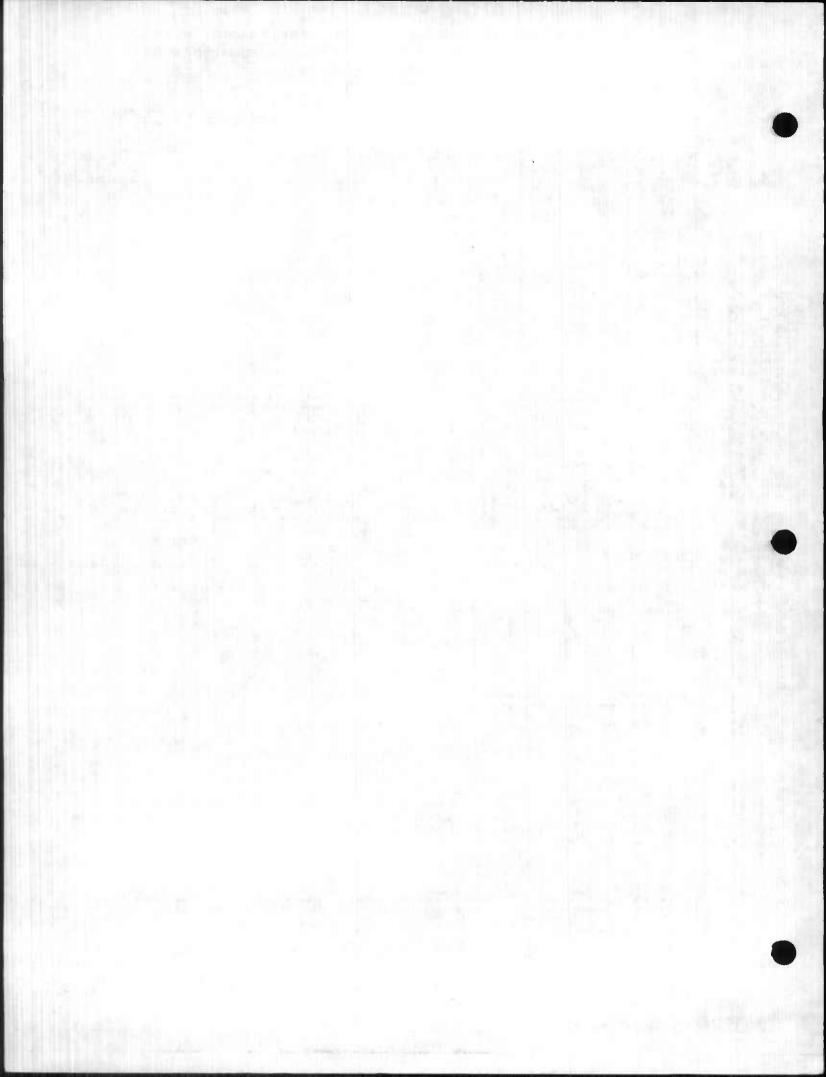
State Registrar

DHMH 16 Rev 6/95



		State of Maryland / Department of Health and Mental Hygiene 0 0 3 6 3 9 6 Certificate of Death Reg. No.
/Me	sician edical	1. Decedent's Nama (First, Middle, Last) 2. Data of Death Month Day Year 3. Time of Death Month Day Year 4b, City, Town, or Location of Death 4c. County of Death
Funer Direct		Mercy Hospice 5,600dal-Security Number 6. Setx 7. Age (In yrs. lest/birthday) H Under 1 Year H Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min. DEC. 6, 936 5. Carolina
Maryland a-f ahow	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A BUTIMORE 11 Yas 2 □ No
death with the Maryland ime 23e or 28e-f show	Funeral Director	106. Street and Number 107. Cipizen of What Country? 212. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-
0020 ours after		11. Marital Status 12. Was Decedent Evar in U,S. Armed Forcas? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Evar in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarlo Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes, Giva Year or Dates:
Aaryland 21215-0020 2 should be filed within 72 hours at and Mentel Hygiens "natural", or la marked other than "natural", or reummic avant, the diese seen	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) Demolition 16b. Kind of Business/Industry Demolition
Maryland 212 d 2 should be filed with th end Mentel Hygiene. 7 is marked other than traumatic event, the	To Be C	17. Fathar's Nama (First, Middle, Lest) Let Dert Isaac 19. Mother's Name (First, Middle, Maiden Surname) Corine Weston
other tr		199. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 10b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 10b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 10b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 10b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 10c. Delta 20c. Location - City or Town, State 10c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 10c. Delta 20c. Location - City or Town, State 10c. Location - City or Town, State 10c. Location - City or Town, State 10c. Location - City or Town, State
Baltimore, permit. Pages 1 a Department of Her Important: if Nam any Injury or othe	BOUCE	21. Signature of Furnital Standard House Control of Furnital Standard House P.A. 21229
)Physicia /Medic Examin	al	Approximate Interval Between Onsat and Death Immediate Cause (Finel disease or condition resulting in death) Due to (or as a consequence of):
oerificate be associated ding physician and se as the burial-transit	/Medical Examin	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Dua to (or as a consequance of): C. Due to (or as a consequance of):
P.O. Box at the death cert i by the attending etached for use	Physician/Med	Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1
cords, requires in been signed should be d	Completed by Pl	Oronia Obstructive Pulmonay Deside 24a. Was an autopsy performed? 24b. Ware autopsy findings available prior to completion of cause of death?
Vital Re- sicien: The lay certificate has irector, page 2		1 Yes SQNo 1 Yas 2 No
O A STE	ation: To Be	25. Was casa referred to medical examinar? Yes 2 2 2 2 2 2 2 2 2
Division tal or Attending by after death. 'it Director: After led in by the fune	Certification:	3 Suicide 4 Homicida 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)
The Hough	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and dua to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred at the time, date and place, and dua to the cause(s) and manner stated.
5 3 6 8	M	29c. Signature and title of certifier 29d. Date signed (Month, Day, Year)
1	7.0	D40854 November 13,2000
	State	30. Nema and address of person who completed ceuse of death (Item 23a) (Type, Print) DAVID RISEDER 9 30/STPAU/P/ BAITIMORE MU2/202 31. Data filed (Month, Day, Year) 32. Registrar's Signature
100000	strar	NOV 1 6 2000 Deneve & Sparks

DHMH 16 Rev 6/95



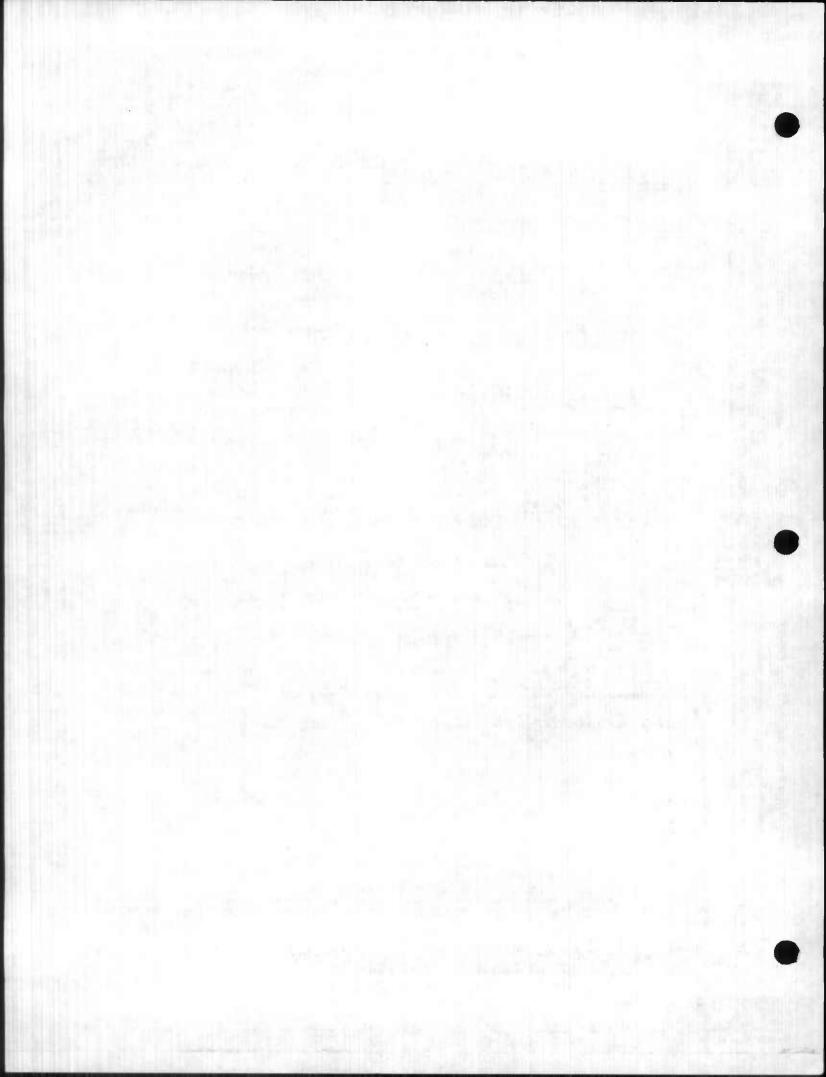
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State of Maryland / Department of Health and Mental Hygiene 00 36397

					Certificat	te of De	eath		Reg. No.		00001
			1. Decedent's Nama (First, Middle, Last)				2. Data of De		Vaca	3. Time of Death
i .	Physicia		HAL D JOH	INSON				Month NOV	Day 2	Yaar OOO	8:14 PM
	/Medic Examin		4a Facility Nama (If not institution, giva			4b. (City, Town, or Lo	cation of Dealt	4c. County	of Death	
	_ CAUTITIT		UNIVERSITY	HOSPITAL		6	PALTIMO	RE	N	IA	
-	Funeral		5. Social Security Number, 6. Se			r 1 Yaar If	Undar 24 Hrs.	8. Dale of Birt	h	9. Birthpl	ace (Stata or Foreign
	Director		219 - 60 - 3512 10 Usual Residence of Decedent	8M 2□ F	48 Yrs. Months	Days	Hours Min.	NOV. 3	1952	Mary	Mand
	E		10a. State 10b. County	10c. Cit	ty, Town or Location					10	d. Inside City Limits
	se Maryta Re-f sho Milled at	Director	MD NA	B	altimore						1 Nes 2 No
	leath with the M ne 23e or 28e-f ment be notifie		623 Roundviel	w Rd.	2	1225			USA of V		
020	urs after de af, or items Examiner, m	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Evar in U Armed Forcas? 1 ☐ Yas 2 ☐ No If Yes, Give Year or Dates:	13. Was Dece		anic Origin? (Sp Mexican, Puarto Specify:	ecify Yes or No Rican, etc.)	- 14. Rac Blac Specify	e - America ck, White, e	
21215-0020	"natur	Completed	15. Decedent's Edu (Specify only highast grad	icetion le completed)	16a. Decedent's Usu (Give kind of wo	ork done duri	n ng most of work	ing	16b. Kind of Bu	usiness/Ind	ustry
	od with	Comp	Elementary/Secondery (0-12)	College (1-4or 5+)	Pipe F	itter	2		Stee	/	FORM
yland	Mental H serked oth affic aven	To Be	17 Father's Name (First, Middle, Last), Christopher C. J.	ohnson SR.		18	Mary C	Smith	Maiden Surnam	na)	
, Mary	and 2 sh sath and m 27 is m		Sanara Johnson	7 - WIFE	307 Lin	odera	Number or Aur	TIEN BU	rnie, m	02/	061
more	Pages 1 sent of Hs nt: If Itsen ry or oth		20a. Method of Disposition 1 Burial 2 Occeptation 3 4 Oceanion 5 Other (Specify)	Removal from State	Place of Disposition (Na cemetery, crematory or PTO CPMO	other place)	j	Date 15-00	Catons		wn, State
Balti	Departri Departri Importa any Inju		21. Signature of Fuginal Service Licens	1//	P2 Name a	nd Address o	The Fu	neral l	Jome F	P. A.	20
			238 Farty Enter the duesan or comb	iculions that caused the deal	h Do not enter the mo	de of dving s	such as cardiac	or respiretory a		212	Approximate
9			23a Farth Enter the guesse, or composition of healt failure. List only o	ne cause on each line.				,			Interval Between Onset and Death
,	hysician /Medical		Immediata Cause (Final								
	Examiner		disease or condition resulting in deeth)	· PSENDOMI	ONAL PNEL	UMONI.	A			1	i week
		-		Due to (or as a consequence of)):				1	,
	g is	Examiner		MYCOBAC	TERIAL PA	VEVMO	NIA			i	1 week
	artificate be executed ing physician and e as the bunal-transit	хап	Sequentially list conditions,	Due to (c	or as a consequence of)):					
90			fl any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated avents	c.							
68760,	certificate be nding physicia use as the bu	edical	that initiated avents resulting in death) Last	Dua to (c	or as a consequence of):	:					
9	and but a see	2									
Вох	th ce	an/		a							
	the death y the atter sched for u	SC	Part II. Other significant conditions co	ntributing to death but not res	ulting in the undertying	cause given	In Pert I.	23b. Did	tobacco uss co	ntributs to	the causs of death?
P.0.	by the	5	1					10	Yes 2000	3 Prob	ably 4 Unknow
	S P P P	þ	AUTO IMMUNE OF	EFICIENCY SY	NOROME						DETECT.
of Vitai Records,	law requiras that the death cer as been signed by the attendin 2 should be detached for use	Completed by Physician/	ANEMIA					24e. Wes perfo	an autopsy ormed?	ava	re autopsy findings illable prior to inpletion of cause death?
Re	The law ata has page 2	ם						40	a de		
<u> </u>	ysician: The is s certificate ha director, page	ő						10		11	Yes 2 No
5	clan	Be	25. Was cese referred to medical axaminer?	Hospital:		Other	6. Place of Deat				
0	Physician: this certific ral director,	70	TO THE PER NO	1 Inpatient 2L	ER/Outpatient 3 D	OA			dence 6 Oth		")
		on	27. Menner of Death Natural 5 Pending	28a. Dete of Injury (Month, Day Year)		28c. Injury at Work?	200	280. Describe	how injury occur	790	
Sio	Attending # death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be		М	1 Yes	2 NO				
	or Attendent The deat Director: In by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	oma, farm, street, factor (y)	ry, office		28f. Location (City or To	Street and Numb wn, State)	ber or Rura	l Route Number,
۵ ,	T T T T T T T T T T T T T T T T T T T										
Contract of	A TAN	edical	29a. Certifier (Check only one) Certifying Phy 2 Medical Examl	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death occurred tion and/or investigation	d et the time, n, In my opini	date end plece, ion, deeth occurr	end due to the red at the time,	cause(s) and ma date and place,	anner as st and due to	ated. the cause(s)
18	To the	×	29b. Signatura and title of certifier		29	c. Licensa n	umber		29d. Date signe	d (Month, I	Day, Year)
	10		Cynthu & Bun	in MD		P141	47		NOV (09.2	000
1	IN	7	30. Nama and address of person who co		n 23a) (Type Brief)	1111	1/			,,-	
1	HI	/	4 4	University Ha	Laita 1 72	Saun 1	100 - CL	est o	the of N	ansula	-d 21201
-	1 4		31. Data flad (Month, Day, Year)	32. Ragistrar's Signa	opinal LL s	10417 6	VECUE DIT	001 1011	11/10/11	7,-	, -, -,
	Stat Registr:	_	MOV 4 A A	Sz. Hagisirai s Signi	1	,					

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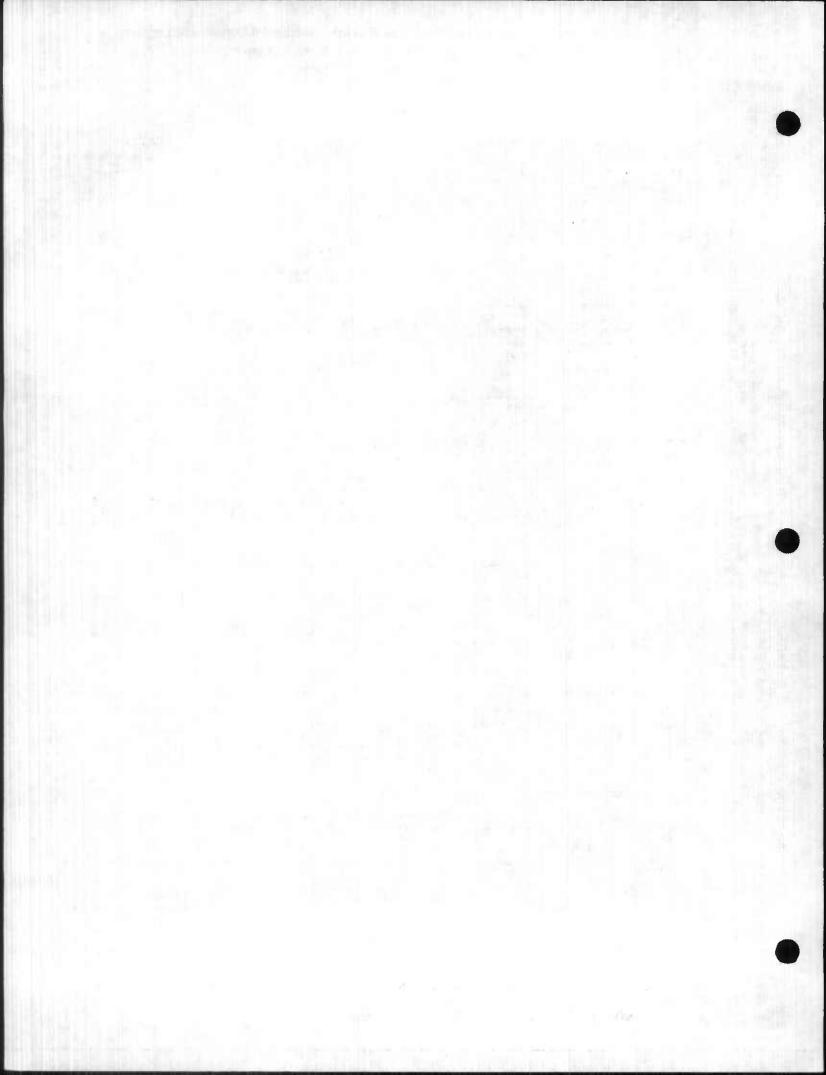
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State of Maryland / Department of Health and Mental Hygiene 00 36398

					Cei	rtificate c	of De	eath			Reg. No.		00000
Dhun	ialan	1. Decedent's Name (First, Midd	le, Last)							2. Date of De Month	ath Dey	Year	3. Tima of Death
Phys /Me	ician dical	Stella	Franci	s	Jon	es				Novemb			9:25pm
Exan		4a Facility Name (If not institution	n, give street end t	num <i>ber)</i>			4b. C	City, Town	, or Lo	cation of Death		y of Death	
		Manor Care	- Ruxton					Tows	on		Ва	1timo	re
Funer	al	5. Social Security Number	6. Sex		. last birthday)	If Under 1 Ye		Under 24 lours	Hrs.	8. Date of Bir (Month, De	h V Veer)	9. Birthr	place (State or Foreign
Directo		212-05-0084	1□M 2 7 F	94	Yrs.	Months Da	lys n	10015	IVIIII.	Nov 23	1905	Ma	ryland
- 10		Usual Residence of Decedent											
May May		10a. State 10b. County		10c. C	ity, Town or Lo	cation						1	IOd. Inside City Limits
N 18	to	MD Bal	timore	Co	ockeys	ille							1 ☐ Yes 2 ☐ XIO
and and and and and and and and and and	Directo	10e. Street and Number			-	10f. Zip Cod	le				10g. Citizen of	What Cou	ntry?
sath with the Marylu rs 23s or 28s-f sho must be notified at		10881 York Rd					2103	0			US	Α	
E 2 2	Funeral	11. Marital Status		ecedent Ever in I	U.S. 13 1	Was Decedent	of Hispa	nic Origin	7 (Sp	acify Yes or No	14. Ra	ce - Americ	cen Indian.
ter dea ter dea	5	1 Never Married 2 Mar	Armed	Forces?		If Yes, specify C	Cuban, N	Aexican, F	Puerto	Rican, etc.)		ck, White,	etc.
20 1 20	7	3 XWidowed 4 □ Divorced	II Yes,	Give Dates:		1 Yes 2 K	No S	pecify:			Specil	y: Wi	nite
Do no and	P		nt's Education	Dates.	16a Decer	dent's Usual Oc	cupation		-		16b. Kind of B	lucinese/in	dustry
15 n 72 n 25 m	Completed	(Specify only highe	st grade complete	d)	(Give	kind of work do DO NOT use re	ne durin	ng most of	f work	ing	100. 14110 01 0		addity
12 men and an an an an an an an an an an an an an	g.	Elementery/Secondery (0-12)	College n/a	(1-4or 5+)	1110.	Homem					Ow	n Ho	me
D BEER		17. Father's Name (First, Middle,	1	a		Homen			Name	/First Middle	Maiden Sume		
C 8 10 1	8	William Norris								Scholl	Walder Carre		
No of the last	2												21020
Maryland 21215-0020 of 2 should be filed within 72 hours at the and Mental Hydions. 77 is meaked other than "natural", or trearmetic event, the Medical Example treams		19a. Informant's Name/Relations Mary Francis		nioco/n	19b. Maili	ng Address (Str	eet end	Number o	Or Ruri	Roy 1	9r, City or Town	, Stete, Zip	sville, MD
		-	SIMMONS/					, .	0.				
Pages 1 a nent of Hear nt. If Hern ry or othe		20a. Method of Disposition 1 ☑ Burial △2 ☐ Cremation	3 Removed trop		cemetery, crei	sition (Name of metory or other	r piece)		1	Date	20c. Location	- City or To	own, State
F Page 1		4 Donation 5 Other (5			rkwood	Cemete	ery		11/	18/00	Parkv	ille,	MD
A HERNA	4	2) Signature of Funeral Service	Vice Suc		22	2. Name and Ad	idress of	f Facility				-	
m sass	8	Dygona	K. Mr.	4)		emmon_F						210	00
			complications that	t caused the des	ath Do not ent	0 W. Pa	don s	la ro	rdiac o	Timon or respiratory a	lum, MD	210	Approximate
9	-	23a. Part1. Enter the disease, o shock, or heart failure. List	only one cause or	eech line.			-,g,			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			Interval Between Onset and Death
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Examine		disease or condition resulting in death)	8.		1220	ND						- 1) (Month
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87 sate street	edical	that initiated events resulting in death) Last		Due to (or as a conseq	juence of):							
X 6	Me												
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. 0 00	Physician	Part II. Other algnificant conditi	ons contributing to	death but not re	sulting in the u	nderlying cause	given ir	n Part I.		23b. Did	tobacco una c	ontributa t	o the cause of death?
5 to 5	Å.									10	Yea 2 No	3 Pro	bably 4 Unknown
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of Vital Physician: This certificate rai director, pe	o Be	25. Was case reterred to medica exeminer?	Hospital:	74 4 4 65	7	-0	Other			h (Check only			
o hy	-	1 ☐ Yes 2 X No 27. Manner of Death		Inpatient 2	ER/Outpetier	IL SLI DOA					denca 8 Ot	-	(y)
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Attending or death.	cal	2 Accident Invest 3 Suicide 6 Could	not be	(-1. A.)				2	-	not 1 pastion /	Street and Mum	har or Bu	el Route Number,
Division of Attending after death. Director: After d in by the fune	Certification:	4 ☐ Homicide determ	nined 20e. Fle	ice of Injury - At I Iding, etc. (Spec		reet, factory, offi	ICB			City or To		Der Dr Hur	ar Aouta Number,
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To With	×	29b. Signature and title of certific	1/	1		29c. Lic	ense nu	Imber	, 1		29d. Date sign	ed (Month,	Day, Year)
		1 / 1/	w	0		77 170	DI	15	4	(7)	Novemb	er 14	, 2000
1100	1	30. Name and address of person	who completed ca	use of death (tte	em 23a) (Type,	Print)		1					HIRET I
10"		Mohammad Rahnar	na, MD 8	100 Har	ford Ro	ad, Bal	Ltim	ore,	Ma	ryland	21234		
5	State	31. Date filed (Month, Dey, Year,	32.	Registrar's Sign	neture 2	. 10						10	
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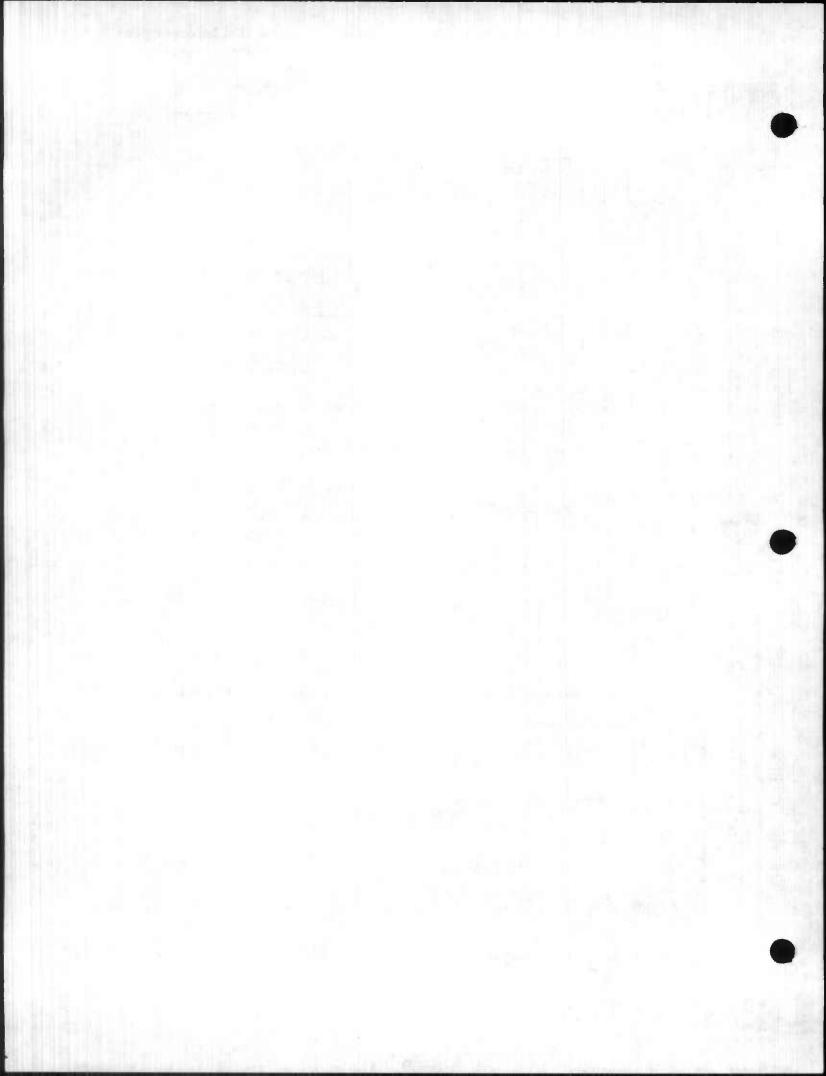


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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Robert Kilroy 4b. City, Town, or Location of Death 13,2000 11:55AM /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Frederick Frederick Frederick Memorial Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 F Yrs 76 235-32-6263 Director Nov 10, 1924 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination is a profited at an ordinal and any injury or other traumatic event, the Medical Examination is an ordinal at a profited at a profited at a profited at a profit. 10a. Stete 1 ☐ Yes 2 ☑ No Director Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21042 U.S.A 10102 Carillon Ct. Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 12. Was Decedent Ever In U,S. Armed Forces? 11. Merital Status 1 ☐ Yes 2 ☐ Myo If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 DNo Specify: Specify. White p 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Paper Mill 5+ Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) Be Novella Agnes Garner Robert Joseph Kilrov 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Pnnt) 10102 Carillon Ct. Ellicott City, Maryland 21042 Ms. Deborah B. Kilroy 20b. Placa of Disposition (Nama of cemetery, crematory or other placa) 20c. Location - City or Town, State 20e Method of Disposition 1 ☐ Burial 2 ☐ Ocemation 3 ☐ Regional from State 11/15/00 Sykesville, Maryland 4 Donation 5 Other (Specify) All County Cremation Services, Ind. 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 M00535 22a. Part 1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition rasulting in death) /Medical Myo cardia 30minutes Examiner Dua to (or as a consequence of) Examin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last signed by the attending physicien and id be detached for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Short from Right to left Circulation p 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy peen this certificate has 1 Yas 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28s. Date of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred al or Attending P. safter death. Certification: 1 Natural 5 Panding investigation 1 ☐ Yas 2 ☐ No 2 Accident 3 Suicide 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 T Homicida To the Hospital o within 24 hours af To the Funeral Di 1) Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Nov 15, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9501 Ellicota City My 190 MD Annapolis 32. Registrer's Signature State ookster. Registrar

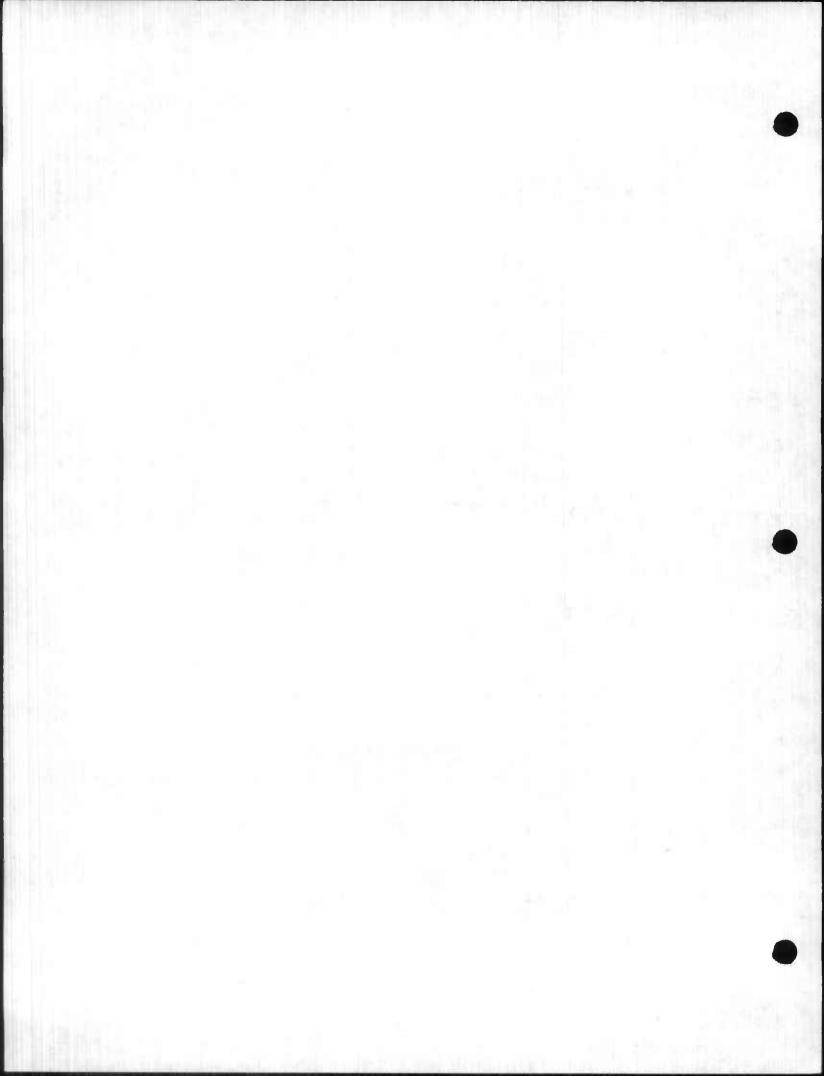
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State of Maryland / Department of Health and Mental Hygiene 00 36400

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ent.	17. Father's Nama (First, Middla, Last,) =			18. Mothar's Ne	ma (First, Middla,			-11.01
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N DE P	19a. Informant's Name/Ralationship (Type, Print)	19b. Mail	ing Addrass (St	reet and Number or R	ural Routa Numbe	er, City or Town,	Stata, Zip	Coda)
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State	31. Deta filed (Month, Day, Year)	32. Registrar's	Signatura	/				_	



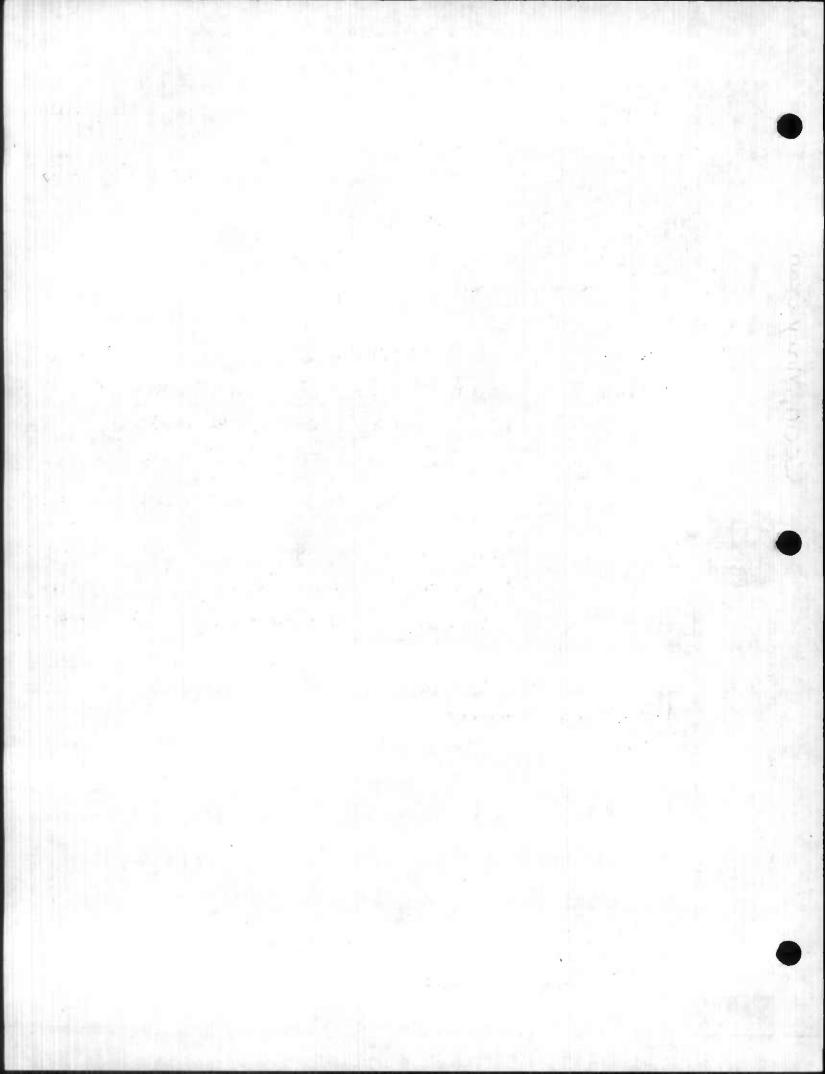
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State of Maryland / Department of Health and Mental Hygiene

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	or 28s-f s or course	10e. Street and Number	101111111111111111111111111111111111111	M. Zip Code		100	2. Citizen of What C	Country?
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	Me Me	29b. Signature and title of certifier		29c. Licans	a number	29	d. Data signed (Mo	nth, Day, Year)
	0/1	1 Town		D3	623		10/14/01	3
	VII	30. Name and address of person who complated causa of death (II	tem 23a) (Type, Print)		ACAR III			
/	UNU	JAMES A. DUGAT, NO 6		Marin	97 5	THE 4 WS	BACTO	MD ZIZOY
	State	31. Data filed (Month, Dey, Year) 32. Registrar's Sig	gnature	1	,			

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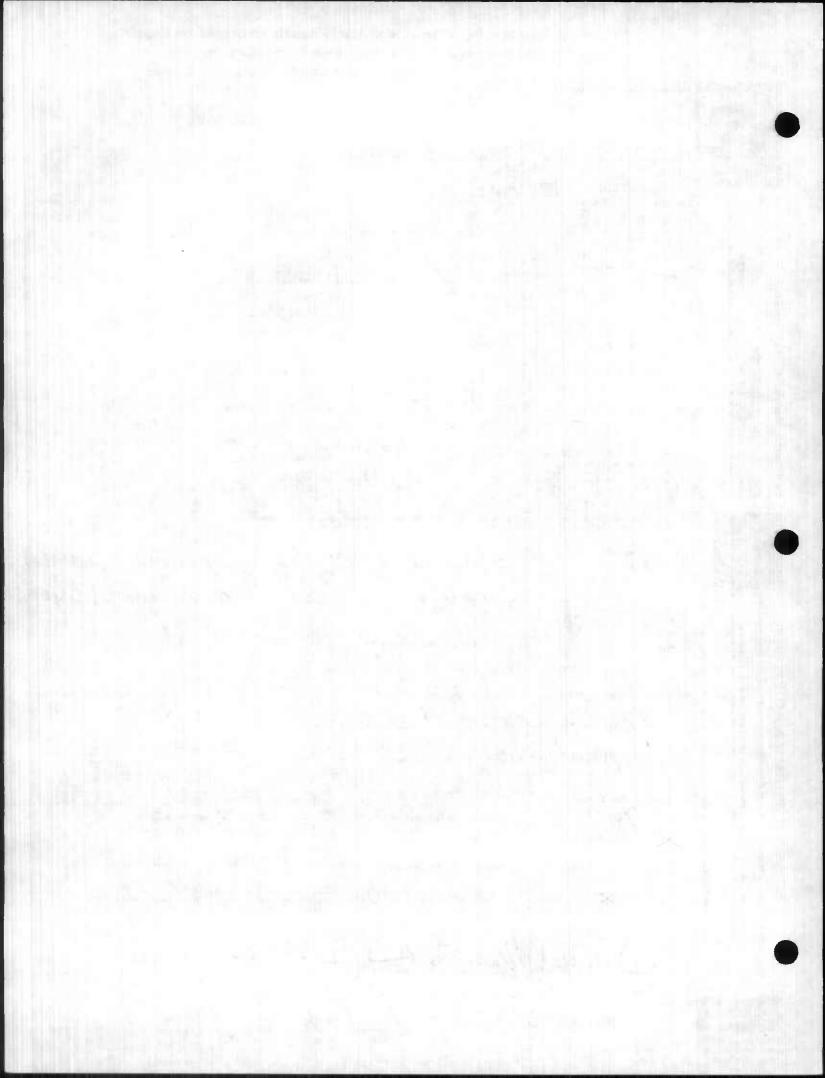


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State of Maryland / Department of Health and Mental Hygiene

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Garage de Company	MR & MRS . CLAR 20a. Method of Disposition	ENCE BOOK	20b. Place of Disp		MADA	Data	_	City or Town, Stata	
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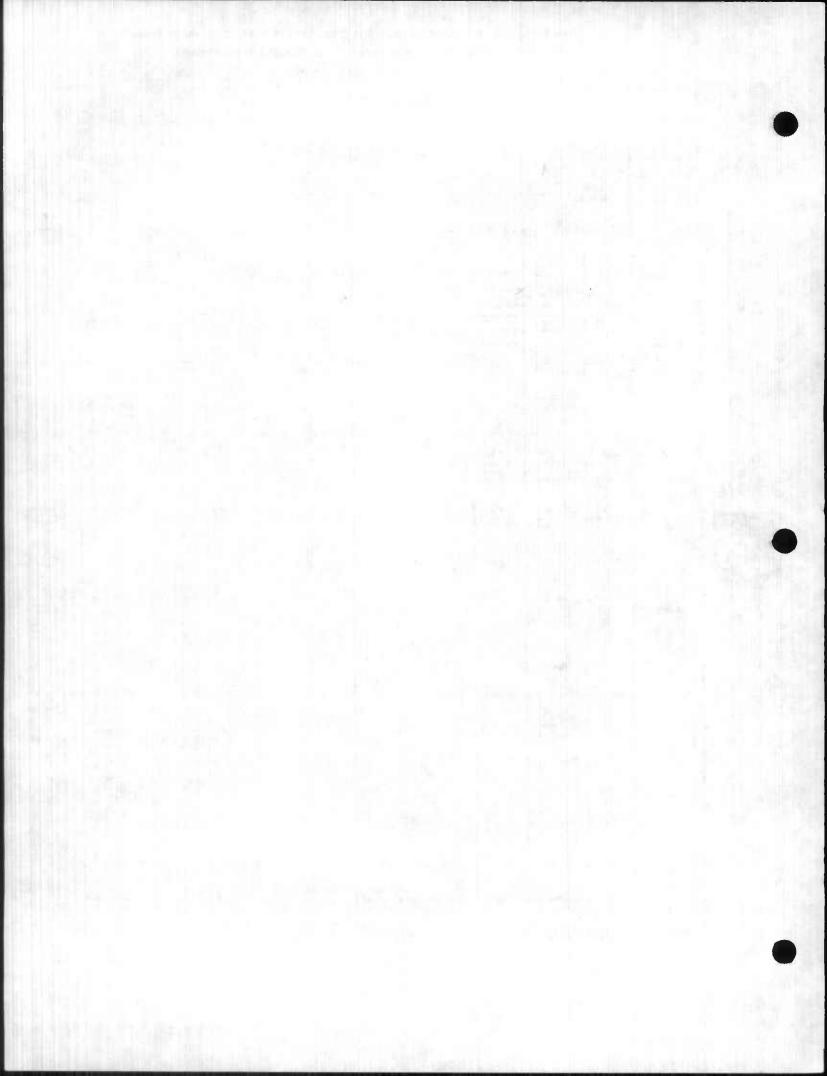


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State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36404 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** GOLDIE 8:42 PM LURIE November 13 2000 /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital of Baltimore Baltimore City N/A | Months | Days | Hours | Min. | S. Date of Birth (Month, Day, Year) | NOV .15, 1911 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2 F 216-01-3347 88 Yrs. Director LATVIA Usual Residenca of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Director N/A BALTIMORE 10f. Zip Code 10e. Street and Number 10g. Citizen of Whet Country? 7015 PARK HEIGHTS AVENUE 238 21215 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian Bleck, White, etc. 1 Never Merried 2 ☐ Married 5 1 ☐ Yes 2X No Specify: WHITE Specify: þ If Yes, Give Year or Dates 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) SALES RETAIL 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) 2 should be f and Mental h MOSES LURIE VERSOK 19s. Informant's Neme/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: if Nem 27 is many Injury or other traum any Injury or other traum KALMAN HETTLEMAN / NEPHEW 5504 WEXFORD ROAD - BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 Burlal 2 Company 3 □ Removel from Stete 4 □ Donation 5 □ Other (Specify) BETH TFILOH CEMETERY 11/15/00 WOODLAWN, MD 4 Donation 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 as that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, use on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical . Acute gastrointestinal bleed Iday Examiner Due to (or es e consequence of) Examiner attending physician and for use as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequenca of): Box 68760 Physician/Medical that Initiated events resulting in death) Last Due to (or as a consequenca of) Pert If. Other algniffcant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? been signed by t should be detact 1 Yes 2 No 3 Probably 4 Unknown Atrial fibrillation Division of Vital Records. à 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? Congestive Heart Failure 1 ☐ Yes 2 No 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2□ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Investigation death. 1 Yes 2 No 2 Accident after death Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) end manner es stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier November 13, 2000 Weber, D.O

State Registrar

latient known as Goldie

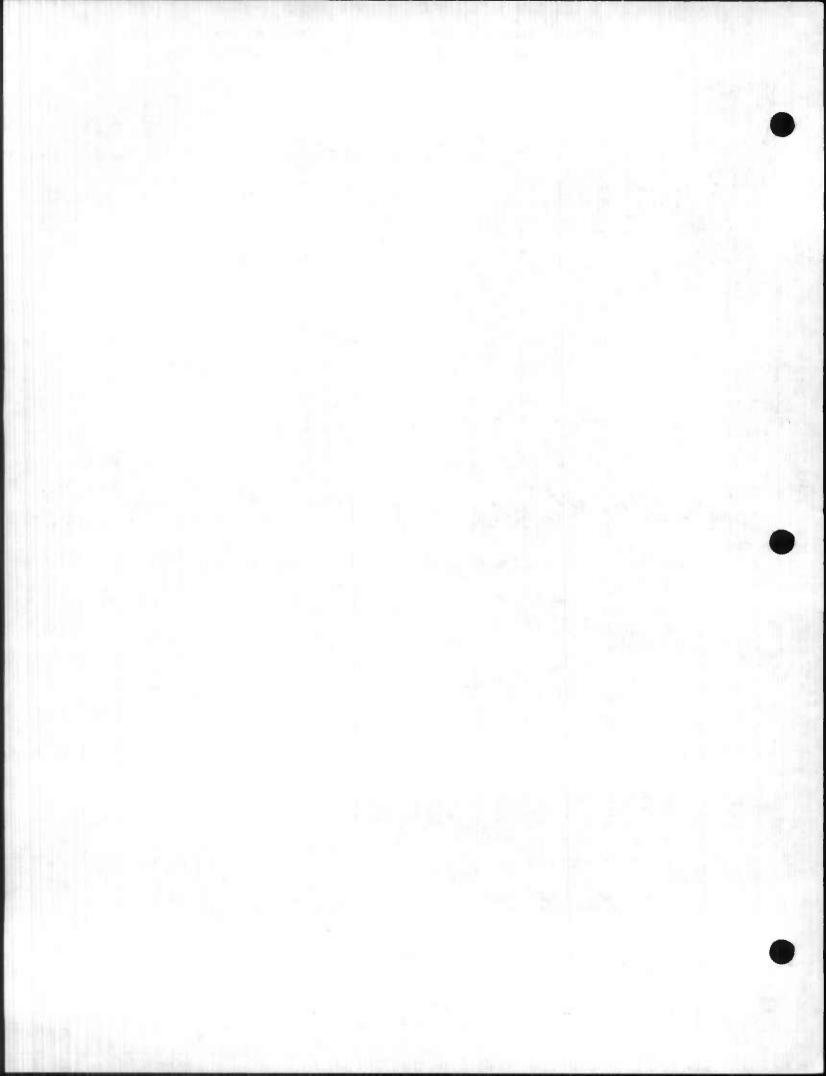
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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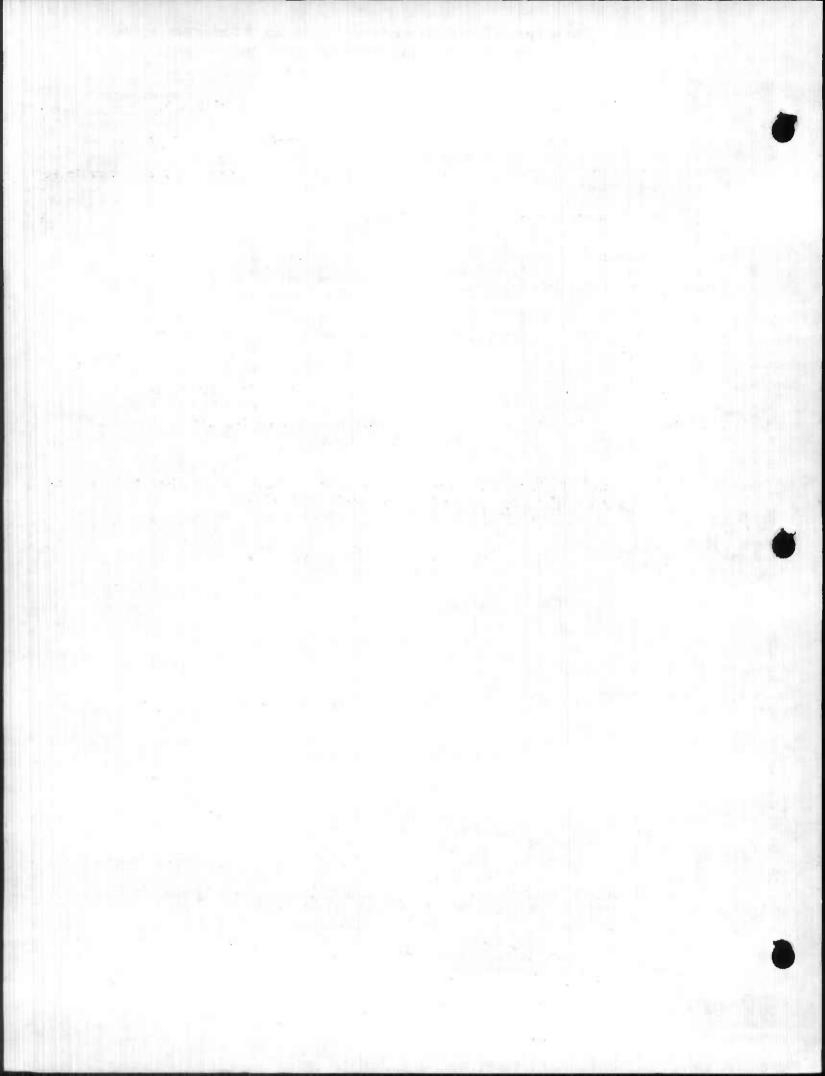
32. Registrar's Signature



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State of Maryland / Department of Health and Mental Hygiene 0 36405

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36406 Certificate of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Day Month Yaar 2:30 pm EGGY OUCKS November 11 2000 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not institution, give street and number) BAYVIEW MEDICAL If Undar 1 Yaar Months Days SALTIMORE If Undar 24 Hrs. 8. Da HOPKINS JOHNIS 5. Social Sacurity Number 8 Sex 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) 8. Data of Birth (Month, Day, Year) 10 M 2 F Min. Hours 484-68-1956 49 Sept 10, Iowa Usuei Residence of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Harford Aberdeen 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 623 Shirley Drive 21001 USA 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ੴ No If Yes, Give Yaar or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14 Bace - American Indian Biack, White, atc. 1 Never Married 2 Married 1 ☐ Yas 2 No Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Collega (1-4or 5+) Elementery/Secondary (0-12) public school system educator 18. Mothar's Nama (First, Middla, Maidan Sumama) unk 17. Father's Nema (First, Middle, Last) unk 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) William Loucks/spouse 623 Shirley Drive Aberdeen, MD 21001 20b. Place of Disposition (Nama of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremetion 3 Ramoval from State 4 Donation 5 Other (Specify) 21. Signatura of Eunarel Service Licensee Ronald S. Wade Director Name and Address of Facility alley Drive Jessup, PA 18434 00 Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediata Causa (Final disaasa or condition rasulting in death) SEPSIS Dua to (or as a consaquance of): NEUTROPENIA Sequentially list conditions, if any, laading to immediata cause. Entar Underlying Causa (Disaesa or injury that initiated events rasulting in death) Last Dua to (or as a consequence of) MYELOMA MULTIPLE Due to (or es e consequance of): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 25 No 3 Probably 4 Unknown NEURO FIBROMATOSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 22000 1 Yas 2 No 25. Was case referred to medical axaminar? 26. Placa of Deeth (Check only ona) Hospital: 1 Inpatiant 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 27. Mannar of Death 28d. Dascribe how injury occurred 28c. injury at Work? 1 Natural 2 Accident 5 Pending invastigation 1 ☐ Yas 2 ☐ No 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicide 6 Could not be 28e. Placa of Injury - At homa, farm, straat, fectory, office building, etc. (Specify) 4 Homicide

physician and s the burial-transit the death certificate be executed 88 attending i signed by the a been signature page 2 s this certificate has Hospital or Attending Physicien: director, After after death. Director: / within 24 hours a
To the Funeral D

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylar Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show empt injury or other treumatic event, the Medical Example and the notified at once.

Physician

/Medical

Examiner

Physician/Medical Examiner

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Completed

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Certification:

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Baltimore, Maryland 21215-0036

P.O. Box 68760. Division of Vital Records,

> State Registrar

31. Data filed (Month, Day, Year)

29a. Certifier

29b. Signatura and title of couling

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29c. Licanse number

Certifying Physician: To the best of my knowledge, deeth occurred at tha tima, date and place, and due to the cause(s) and manner as stated.

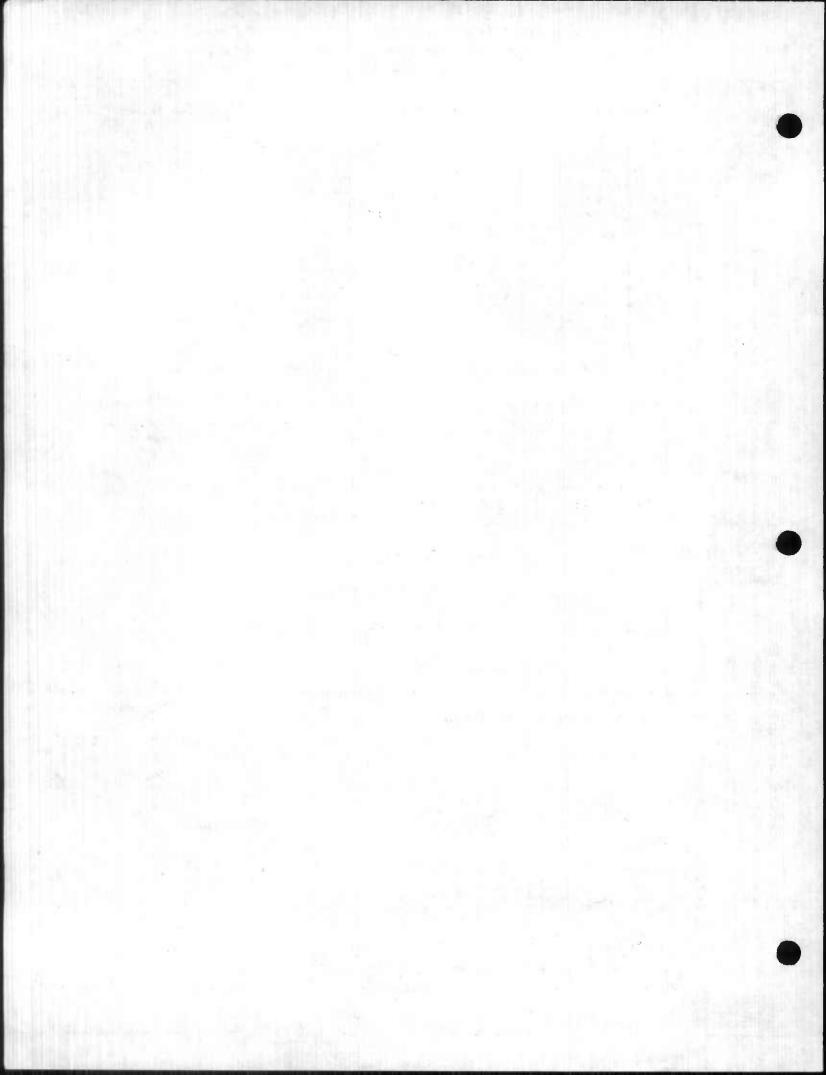
| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

November

30. Nama and addrass of who completed causa of death (Item 23a) (Type, Print) erson LURTUZ

HOPILINGS JOHNS 32. Registrar's Signatura

BAYVIEW MED CTE, 4940 EASTERN AVE



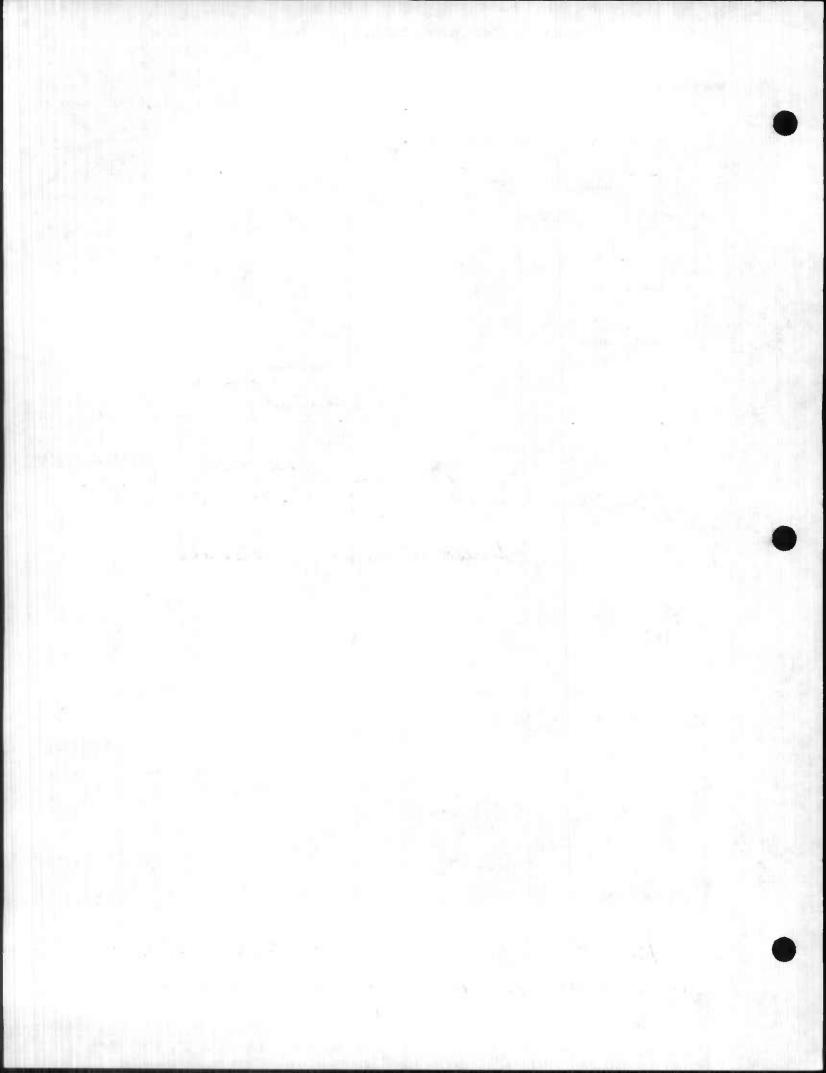
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decement's Name (First Middle Last) 2. Data of Death 3 Time of Death Month Dey 11, 2000 **Physician** 8:24 PM Lembach Bernadette /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Nama (If not institution, give street and number) Examiner Baltimore City Johns Hopkins Bayview Medical Ctr. 5. Social Security Number If Under 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) Dec. 30, 1928 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Deys Hours 1 □ M 2 🖾 F Yrs. 71 Director Maryland 220-24-4083 Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Dundalk 1 ☐ Yes 2 No Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 21222 United States 7980 St. Monica Drive Funeral 14. Raca - American Indien, Black, Whita, atc. 12. Was Decedent Ever in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1 ☐ Yas 2 ☑ No If Yes, Giva Yaar or Datas: 1 Nevar Married 20XMarried 21215-0020 1 ☐ Yas 2X No Specify Specify. by 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 10 Years Saltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be ind Mental Clara Imhoff George Hillenbrand 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 21222 7980 St. Monica Drive Dundalk, Maryland Health Hem 27 i Mr. Charles R. Lembach (Husband) 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition B 1 ☑ Burial 2 ☐ Crametion 3 ☐ Removal from Stata à Rossville, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) Gardens of Faith Cem. 11/15/2000 21. Stonatura of Funaral Sarvica Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. aure Dundalk, Maryland 23a. Part . Entar tha disaase, or complications that caused tha death. Do not entar the mode of dying, such as cardiac or raspiratory arrast, shock, or haart failure. List only one causa on each line. Approximate Intarval Batween Onsat and Death **Physician** arteriosclaratic carmony artery descare /Medical Immediate Cause (Final disease or condition resulting in daath) **Examiner** Physician/Medical Examiner use es the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, laading to immedieta causa. Entar Underlying Cause (Disaasa or injury Dua to (or as a consequence of). Box 68760, that initiated evants rasulting in death) Last Due to (or as a consequence of): P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 1 Yas 2 No 3 Probably 4 Unknown py of Vital Records, 24b. Wara autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? page 2 should 1□ Yas 2□No 1 ☐ Yas 2 ☐ No or Attending Physician: 25. Was case referred to medical axaminer? 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatiant 2 DER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Yas 20 No 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28c. Injury at Work? Division 5 Pending invastigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accidant the 6 Could not be detarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicida 28a. Placa of Injury - At homa, farm, street, factory, offica building, atc. (Specify) in by 4 ☐ Homlcida fo the Faneral 1 Certifying Physician: To the best of my knowledge, daath occurred at tha time, date and place, and due to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, daath occurred at tha time, date and place, and due to the cause(s) and mannar statad. 29a. Certifier To the 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signeture end title of certifian D21022 Marelenh 30. Name and address of person who complated causa of death (Itam 23a) (Type, Print) Kowa wousky 4UTO MI) 2123 C 1672 BELAIR 31. Data filed (Month, Day, Year) 32. Registrar's Signatura

Registrar

6 2000

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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Tima of Deeth **Physician** D:45A /Medical 4a Facility Neme (If not institution, give street 4b. City. Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. last birthday) Yrs. If Under 1 Year 9. Birthpiece (State or Foreign **Funeral** Months Unk 1 M 2 F Director Usuei Residence of Decedent 10b. County 10a Stete City, Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or items 23s or 28e-f show other traumatic event, the Medical Examinar must be notified at Baltimore 1 Ves 2 No Director 10g. Citizen of What Country? Street and Number 10f. Zip Code 194 lod 0 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indian, Biack, White, etc. 11 Merital Stetus 1 Never Married 2 Merried 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Yes 212 No Specify: PV 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiena. Important: If fem 27 is marked other than eny Injury or other transment. Elementary/Secondary (0-12) Coilege (1-4or 5+) truction ath 18. Mother's Neme (First, Middle, Maiden Surname) Father's Neme (First, Middle, Last) Be 2 City or Town, State, Zip Code) U., MD. 2/229 19e. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number 20b. Plece of Disposition (Name of Dete 20c. Location - City or Town, State 20e. Method of Disposition cremetory or other ple 1 Buriel 2 Cremition 3 Remove from State 4 Donetion 5 Other (Specify) 21. Signature of Fundral Service License of dispese, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, the failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** carcinoma /Medical Immediate Quuse (Finel diseese or condition resulting in deeth) Examiner Examiner been signed by the attending physician and should be detached for use as the burial-transit Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): Pert it. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobecco use contributs to the cause of death? Xes 2 No 3 Probably 4 Unknown p 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? 1 Yes 1 Yes 25. Was cese referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Sother (Specify) HOSPICE 1 Yes 20 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Tima of 28c. Injury et Work? 5 Pending investigation 1 WNatural 2 Accident 1 Yes 2 No 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end plece, and due to the cause(s) and menner stated. 29a. Certifier

Division of Vital after death Director:

Baltimore, Maryland 21215-0020

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death.

State Registrar

6 2000 NOV

30. Name and

29b. Signature and title of certifier

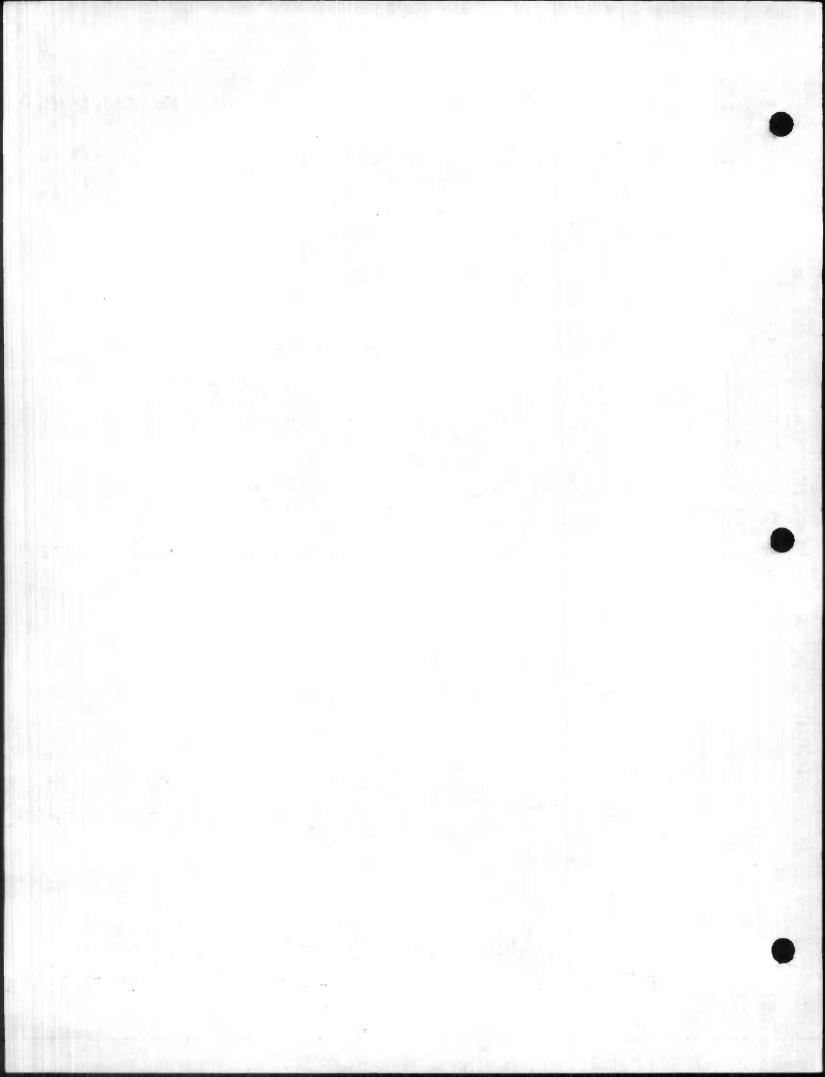
31. Dete filed (Month, Day, Year)

32. Registrer's Signeture

s of person who completed cause of deeth (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Dev. Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36409 Certificate of Death 3. Time of Deeth 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) 00:45 AM 12 NOV 2000 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Name (If not Institution, give street and number) Bultumbre Cit 6. Sex and Hame 5. Social Security Number 2/4-39-48/0 Usual Residence of Decedent last birthday) place (State or Foreign Deys Hours 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Nes 2 No 10g. Cifizen of What Country? 10e. Street and Number 10 á 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: Black 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. PO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) di 18. Mother's Name (First, Middle, ours incen d/2/8 ta alto. Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriel 2 □ Creffiation 3 Removel from State 4 □ Donation 5 Other (Specify) Approximete Interval Between Onset and Death cations that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest List only one ceuse on each li Immediate Cause (Final disease or condition resulting in death) Stomach 1 400 carcinama Due to (or as a consequence of): 11 Arain motestail Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): 1, Liven metastasis Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Wunknown 24b. Were autopsy findings available prior to Diabeles mellitus 24a. Wes an autopsy performed? completion of cause of deeth? 1□ Yes 2 No 1 □ Yes 20 No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Pinpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Examiner attending physician and for use as the bunel-transit that the death certificate be executed Division of Vital Records, P.O. Box 68760. Physician/Medical þ Completed pege 2 s Be 10 funeral Certification: in by

Physician

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Director

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Pages 1 end 2 should be filed within 72 hours efter death with the Marylan ent of Health and Mental Hygiene.
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Department of Health a Important: if Nem 27 Is any injury or other tra-

Physician

/Medical

Examiner

Me Carte Gordon altimore, Maryland 21215-0020

Mecanto

Chanic renal feilure

1 Yes 2 No

27. Manner of Death

3 ☐ Suicide

4 Homicide

6 Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifie (Check only one)

11 certifying Physician: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(s) and manner es stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end place, end due to the cause(s) and manner stated.

29b. Signeture end title of certifies

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

** NETAL Death Medical Control of South Charles streat Balkman MD & 12300

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11/13/00

State Registrar

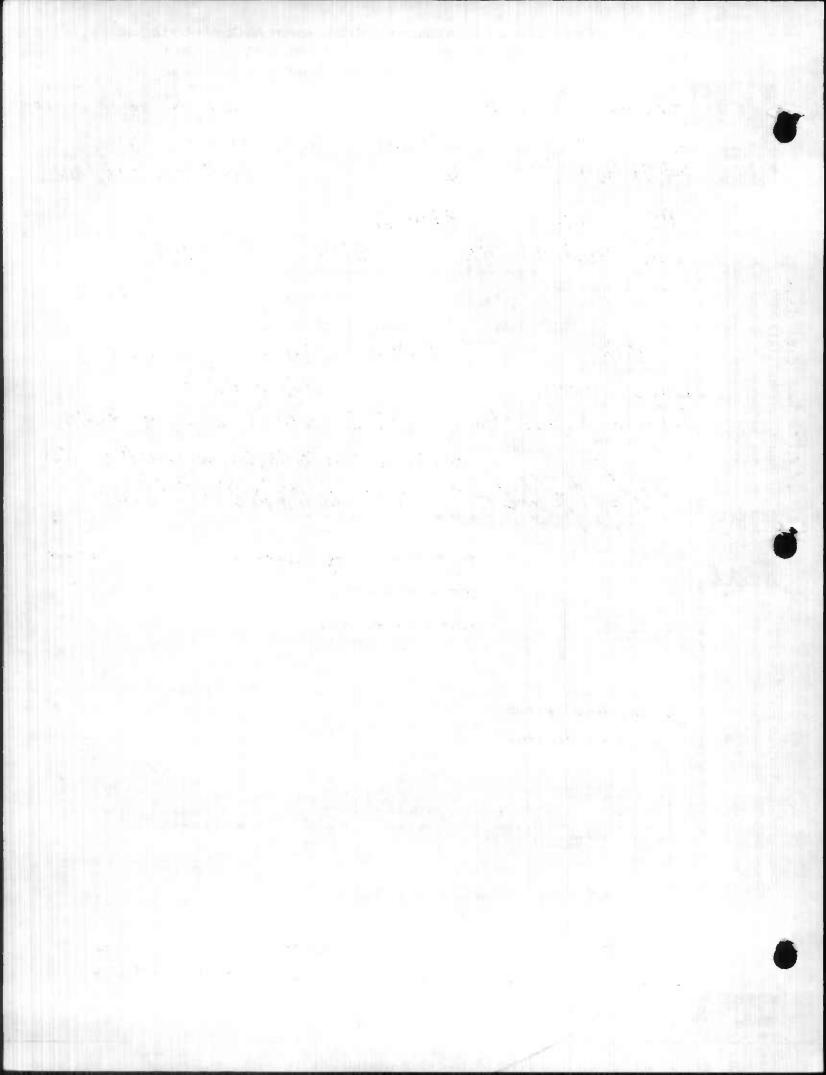
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32. Registrar's Signature

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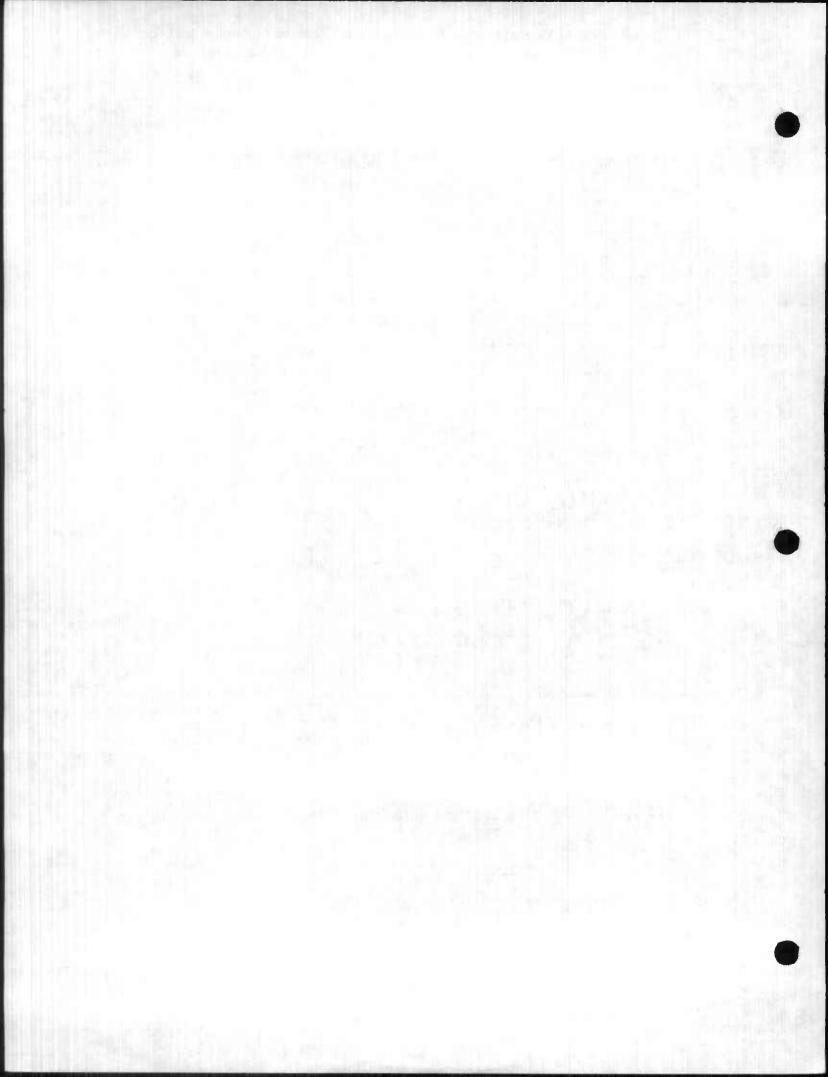


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State of Maryland / Department of Health and Mental Hygiene

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/Medical Examiner	4a Facility Nama (If not institution BonSecour Ho		mber)			4b. City, To Balt		cation of Deati	4c. County		
Funeral	5. Social Security Number	6. Sex	7. Aga (In yrs. les	t birthdey)	If Under 1 Yaar			8. Data of Bir (Month, Da	th	9. Birthp	laca (Stata or Foreign
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dS, Parines that signed I doe det	Upo Gi ble	(1) tenu	v 140/	lioto	lud 1	any	Hunz	4			
Division of Vital Records, or Attending Physician: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be entification: To Be Completed by	1 11 0-10	1 -			10 /	U		24a. Was	an autopsy		ara autopsy findings ailable prior to
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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death **Physician** st Caar Nonent 05 /Medical 4b. City. Town, or Location of Death 4e Facility Neme (If not institution, give street and number 4c. County of Death Examiner BALTIMORE CO. WEST ANDALL If Under 24 Hrs. STOWN 105D;
7. Age (yh yrs. last birthday) If Under 1 Year 6. Sex **Funeral** Months Deys 1□M 2 F 216-66-8192 Usuel Residence of Decedent Yrs. Director with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or hems 23s or 28s-f show traumatic event, the Medical Examiner must be notified at Yes 2□No RANDALLSTOWN BALTIMORE Be Completed by Funeral Director 10f. Zip Code 10a. Citizen of What Country? 10e. Street and Number 100 U. S.A 21133 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 22 No if Yes, Give 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 11. Meritel Stetus 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1□ Yes 2 No WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Detes: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiena. OWN HOME day (0-12) College (1-4or 5+) KER tomE MA 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Pages 1 and 2 should be nent of Heelth end Mental int: if item 27 is marked or HoleH VAN 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) permit. Pages 1 and 2 sh Department of Heelth end Important: if item 27 is m any injury or other treum 2002. 10. V. 14519 MEIGS ONTARIO 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Dete 20e. Method of Disposition 1 Burial 2 Cremetion 3 Removel from Stete
4 Donetion 5 Other (Specify) REMATER 8000 22. Name and Address of Facility MD. 2/224 Approximata Intervel Between Onset and Deeth 23a. Pert 1. Enter the disease, or complications that caused the deeth. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such es cardiec or respiretory Physician Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Due to (or es a cons Examiner To the Hospital or Attending Physician: The law requires that the deeth certificate be executed within 24 hours state death.

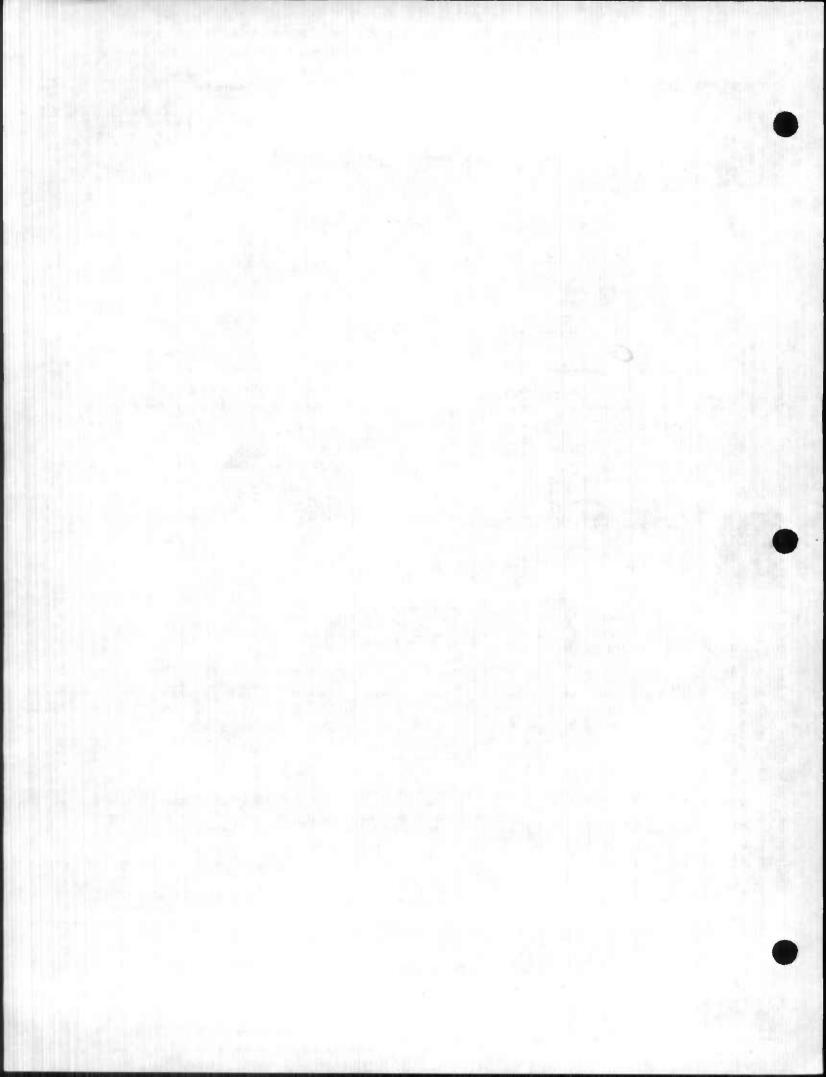
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of) P.O. Box 68760, Physician/Medical Due to (or es e consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. Be Completed by 24b. Were autopsy tindings evailable prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 2 No 1 Yes 25. Wes case referred to medical examiner?

1 Yes No 26. Piace of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 27, Menner of Deeth 28d. Describe how Injury occurred 28b. Time of 1 Neturel 2 Accident 5 Pending 1 Yes 2 No investigation 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 1 Certifying Phyelcian: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29e. Certifier 29d. Dete signed (Month, Dey, Year) 29c. License number 29b. Signeture and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signeture 31. Date filed (Month, Day, Year) State

DHMH 16 Rev 6/95

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 00-6511-510 State of Maryland / Department of Health and Mental Hygiene [] SAMUEL Q. MICKEY Certificate of Death ASP 1. Decedent's Nema (First, Middla, Last) 2. Deta of Death 3. Time of Death Dey Month Yaar **Physician** SAMUEL MICKEY 15 2000 NOVEMBER 0305 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS BAYVIEW BALTIMORE N/A 7. Aga (In yrs. last birthday) 78 Yrs. If Undar 1 Year If Under 24 Hrs 5. Social Sacurity Number 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** Days Hours Months 1 XM 2 F Yrs. **Director** 216-16-1200 13 1922 MD Usual Rasidenca of Decedant 10c. City, Town or Location 10b. County 10d. Insida City Limits r than "natural", or hams 23s or 28s-f show the Medical Examiner must be notified at Director 1 ☐ Yas 2 No BALTIMORE BALTIMORE 10e Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 8429 COVE RD 21222 USA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, apecify Cuban, Mexican, Puarto Rican, atc.) 14. Raca - Amarican Indian, 11. Marital Status Bleck, Whita, atc. 1XXYas 2 No If Yes, Giva 1 Nevar Married 2 Married Maryland 21215-0036 1 ☐ Yas 2 ☐ No Specify: Specify: BLACK by 3 Widowed 4 Divorced Yaar or Datas: WWII Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 12 TRUCKER TRUCKING permit. Peges 1 and 2 should be the Department of Health and Mental Hy importants if Nem 27 is married other any injury or other the 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Be HORACE MICKEY 10 ROSA DUNAVILLE 19a. Informant's Name/Ralationship (Type, Pnint) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) DEBORAH B. MICKEY /WIFE 8429 COVE RD., BALTO., MD. 21222 Baltimore, 20b. Piace of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burlal 2 Cramation 3 Ramoval from Stata 4 Danation 5 Other (Specify) ARBUTUS MEM 11/21/2000 BALTO., MD. 22. Nama and Addrass of Facility
JAMES A. MORTON & SONS F.H., INC 21. Signature of Funeral Sarvice Licenti amesu 1701 LAURENS ST. BALTO., MD. 21217 nown 23a. Par 1, Entar tha disaasa, or corpolications that causad tha daath. Do not antar tha mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Intervel Between Onsat and Death **Physician** /Medical Immediate Causa (Final disaasa or condition resulting in daath) a Arteriosclerotic Cardiovascular Disease Examiner Dua to (or as e consequenca of): Examiner burial-transit Sequantially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last and Due to (or as a consequence of): Box 68760, attending physician certificate be Physician/Medical the Dua to (or as a consequence of) as 980 ò P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yea 2 ☐ No 3 ☐ Probably 4 K Unknown signed by ung Records, þ 24b. Were autopsy findings available prior to complation of cause of death? should l 24a. Was en eutopsy performed? Completed has page 2 INSPECTION

26. Place of Death (Check only ona)

25. Wes case refarred to medical axaminar? Yas 2 No 27. Menner of Death 1 Netural 5 Pending Invastigation 2 Accident 6 Could not be datarmined 3 Suicida

Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year)

28b. Tima of Injury 28a. Placa of Injury - At homa, farm, atraat, factory, office building, atc. (Specify)

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 28d. Dascribe how injury occurred

281. Location (Street and Number or Rural Routa Number, City or Town, Stata)

1 Yes 2 No

29a, Certifier (Check only one)

4 Homicida

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Licanse number

29b. Signature and titla of certifier

O.C.M.E.

29d. Data signed (Month, Day, Year) NOVEMBER 15, 2000

1 ☐ Yas 2 ☐ No

addrass of person who con implated causa of death (Item 23a) (Type, Print)

State Registrar JACKM. TOO

M.D 32 Registrar's Signatura

111Penn Street, Baltimore, Maryland 21201

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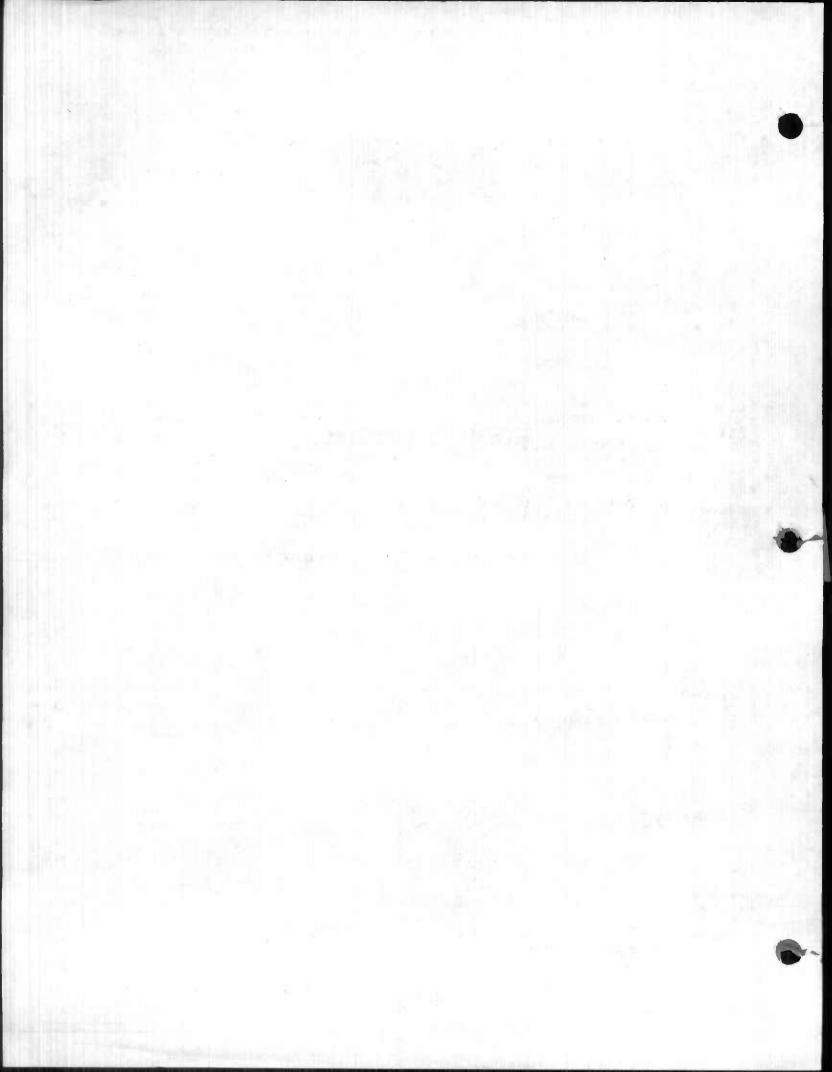
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Division Attending



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Dey Month Year McClain 2000 Timothy 11 Alexander 13 8:00a.m. 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street and number) 4c. County of Death 4406 Old Court Road Apt A Social Security Number 6. Sex 7. Age (In yrs. last birthday) Pikesville tf Under 24 Hrs. 8. Dete Baltimore If Under 1 Yeer 5. Social Security Number 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Months Days 15 M 2□ F 08 54 214-64-8379 M.D Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Pikesville Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21208 U.S.A. 4406 Old Court Road Apt A 14. Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Stetus 1 Yes 2000 No If Yes, Give Yeer or Detes; 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Automotive Company Auto Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Theodore McClain Annette Chase 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21208 Kazerrian McClain-Wife 20a. Method of Disposition 4406 Old Court Road Apt A, Pikesville, 20c. Location - City or Town, State Date 1 Buriel 2 Fremation 3 Removel from State 4 Donation 5 Other (Specify) Metro Crematory Inc. 11/15/00 Baltimore, Md 21. Squa of Funeral Service Licenses 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215 me 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, and a rest and aiture. List only one cause on each line. Approximate Intervel Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) · ACQUIRED IMMUNE PEFICIENCY SYNDROME Due to (or es a consequence of): Sequentially tist conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contribute to the causs of death? 1 Yss 2 No 3 Probably 4 Unknown Anemia 24b. Were eutopsy findings available prior to 24e. Was an autopsy performed? completion of cause of death? 2 2 No 1 Yes 1 Yes 2 No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Neturel 2 Accident 5 Pending 1 Yes 2 No investigetion 6 Could not be determined 3 Suicide Plece of Injury - At home, tarm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

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29b. Signeture and title of certifier

29a, Cartifier

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DHMH 16 Ray 6/95

State Registrar

P. 31. Date tiled (Month, Day, Year)

GRADON 32. Registrer's Signeture

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print)

SINA HOSPITAL, BALTIMORE, MD 21215

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ORIGINAL

Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0042061

29d. Date signed (Month, Day, Year)

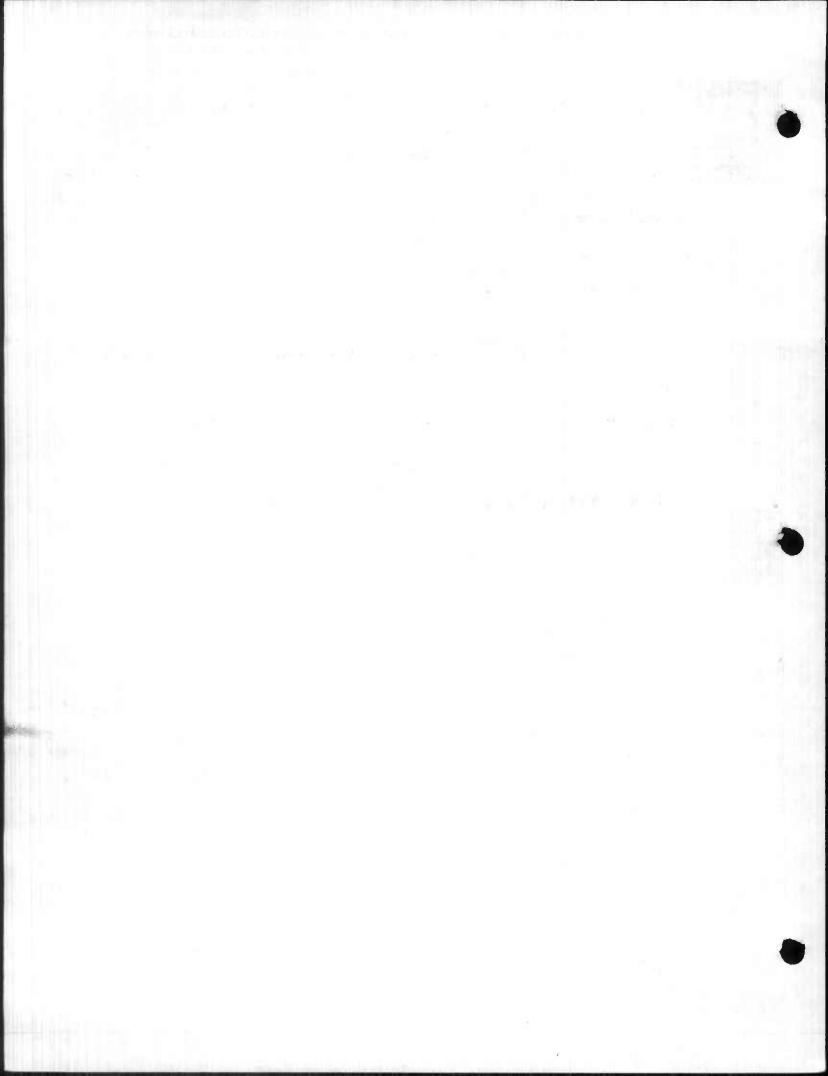
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Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** November 8, 2000 Edith Lois Mendenhall 8:30 AM /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street end number) 4c. County of Death Examiner Mariner Health Overlea Baltimore | Months | Days | Hours | Min. | April 20, 1911 | 9. Birthplace (State Months | Days | Hours | Min. | April 20, 1911 | Alabama 5 Social Security Number 7. Age (fn yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 10 M 25F 420-07-1293 89 Yrs. **Director** Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits or flame 23s or 28s-f show 1 TYes 2 □ No N/A Baltimore Director the Medical Examiner must be notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5728 White Avenue 21206 U.S.A. Funeral 14. Race - American Indian, Bleck, Whife, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0020 Specify: White 1 Yes 2 No Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Buyer Clothing 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) should be Joseph Pickens Sallie (Unknown) 19e. informanf'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Pages 1 and 2 5728 White Avenue Baltimore, Maryland 21206 William Mendenhall/Step Son Department of Health Important: If Item 27 Baltimore, 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 11/13/00 Birmingham, Alabama Elmwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206 thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** PNEUMONIA Immediate Cause (Final diaeese or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequenca of): P.O. Box 68760. Due to (or es e consequence of): Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the causa of death? 1 Yaa 2 No 3 Probably 4 Unknown CORONARY ARTERY Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? DEMENTIA 1 Tyes 2 No 1 Yes 2 No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) 1□ Yes 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 45 Nursing Home 5 Residence 8 Other (Specify) Medical Certification: To

Division of Vital Records, of attending Physician: The law after death.

Director: After this certificate has I in by the funeral director, page 2.

28b. Time of 27. Menner of Deeth 28d. Describe how injury occurred 1 Neturel 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homlcide Is called in provious. To the best of my knowledge, death occurred at the time, dete and placa, and due to the cause(s) and menner as stated.

It was a stated in the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner stelled. 29a. Certifier

29b. Signature and little of contine uce

29c. License number

29d. Dele signed (Morith, Day, Year) 00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

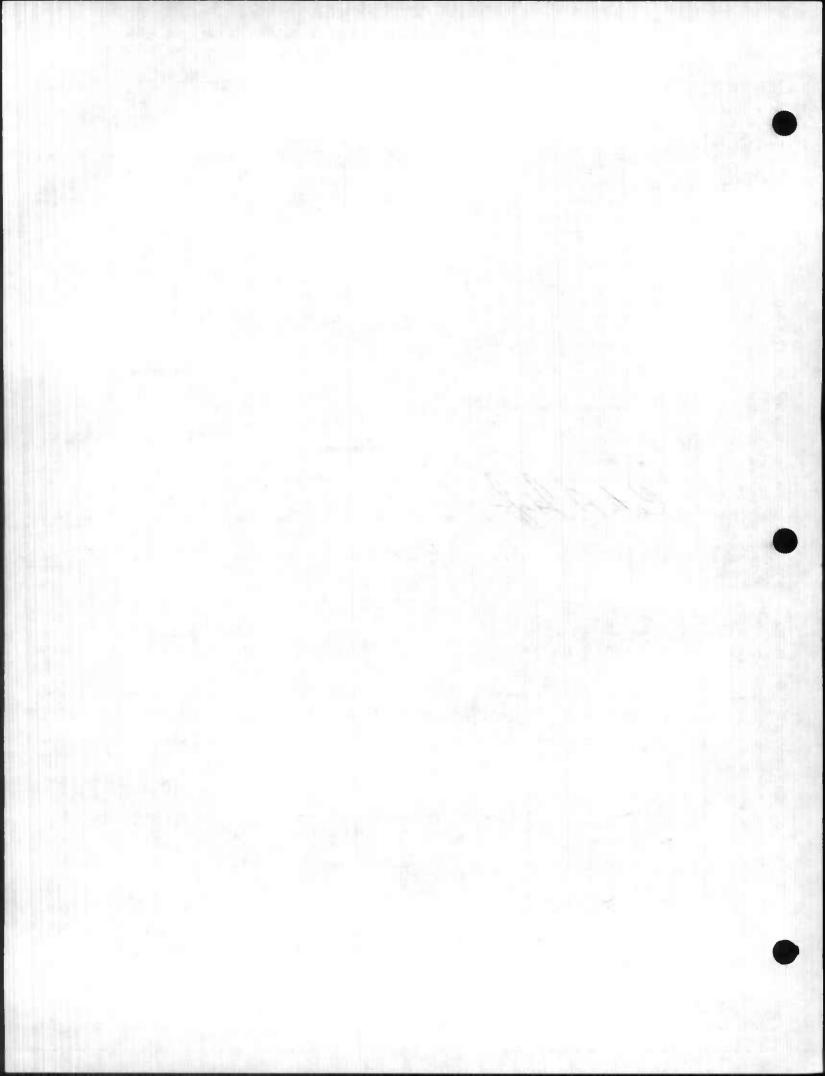
Luis E. Rivera MD. 5714 Harford Road Baltimore, Maryland 21214

31. Date filed (Month, Dey, Year)

32. Registrer's Signature

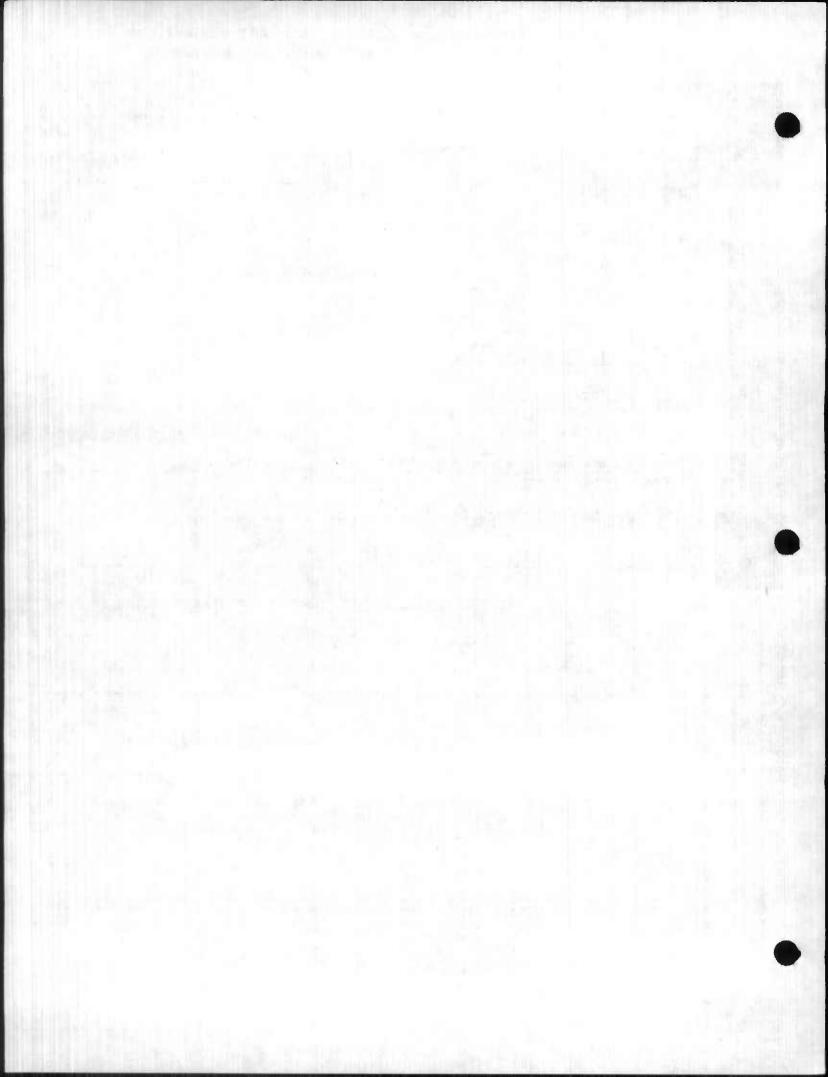
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Registrar



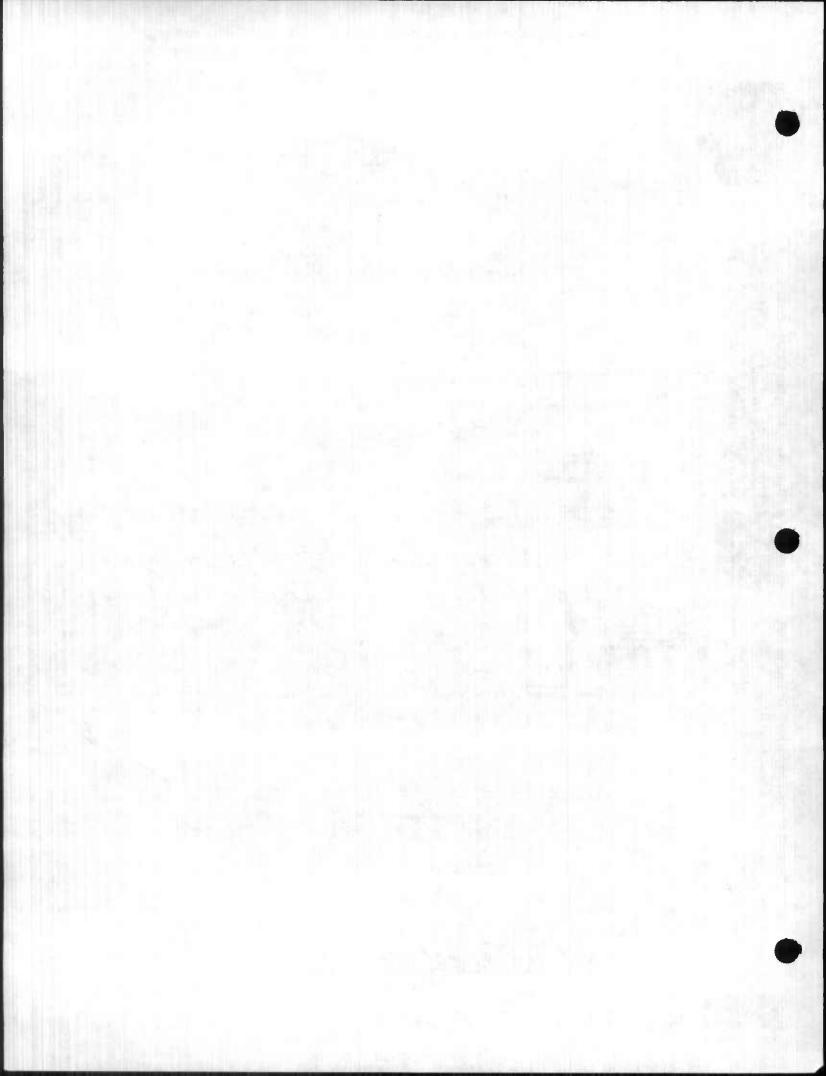
State of Maryland / Department of Health and Mental Hygiene O O

			Certificate of		Reg. No.		0 1 1 0
Physician	Decedent's Name (First, Middle, Last)				Date of Death Month Day	Year	3. Time of Death
/Medical	4a Facility Neme (If not institution, give stre	net and number)		4b. City, Town, or Location	on of Death 4c. Co	unty of Death	Capno
Examiner	Λ- ()	Ral Hospi	tal.	Ractionage	Crty		
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday) If Under 1 Year Months Days		Date of Birth Month, Day, Year)	9. Birthpl	ece (Stete or Foreign ry)
Director	215-54-2939	2DF 48	Yrs.	1	1 05 52		.D.
Du k	Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Location			10	d. Inside City Limits
Many frame	MD NA	Dol+	imore				XXYes 2□No
vith the Mai to 28s-f a be notified Director	MD NA 10e. Street and Number	Dail	10f. Zip Code	200	10g. Citizen	of What Count	ry?
ath with the Meryler 23e or 28e-f show unit be notified at ral Director	706 Deacon Hill	Ct.	2:	1225	U.	S.A.	
72 hours after death with the Maryland natural, or terms 23a or 28a-f show und Executed must be notified at the Executed Director.		Was Decedent Ever in U,S. Armed Forces?	13. Was Decedent of I	Hispanic Origin? (Specify an, Mexican, Puerto Rica	Yes or No- in, etc.)	Rece - America Black, White, a	
Mr, or h	1 Never Merried Merried	X□XYes 2 □ No If Yes, Give	1□Yes 2⊠No			ecify:	
natural, natural, leted by	3 Widowed 4 Divorced	Yeer or Dates:	6a. Decedent's Usual Occu	nation	16b Kind o	Bla of Business/Ind	
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EITE a	17. Father's Neme (First, Middle, Last)			18. Mother's Neme (Fit	rst, Middle, Meiden Sur	name)	
s should be and Mental and Mental and marked o	Charles Norman			Emma L. I			
	19a. Informent's Neme/Relationship (Type,		9b. Meiling Address (Street				
Healt Healt Her ther	Karen E. Norman- 20e. Method of Disposition	20b. Plece	06 Deacon of Disposition (Name of	D		on - City or To	21225 wn, Stete
8 7 2 0	XXBurial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	Invalirom State	rison fore		/21/00 0	wings	Mills.
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	art1. Enterthe disease, or complicat hock, or beart feilure. List only one	tions that paused the death. (MG 2	Approximate Interval Between
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nvieuicai Examiner	Immediate Cause (Finel diseasa or condition	Seos	5				
MICHIGAN	resulting in death) a	Due to (or as	a consequence of):	MEG LT 5		1	
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an and ial-tra	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):			1	
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igned by the elected by the by Physic	Pert II. Other significant conditions contrit	outing to death but not resulting	g in the underlying cause gi	ven in Pert I.	23b. Did tobacco uar		
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requires the sear signs should be defected by					24a. Was en eutopsy		ra autopsy findings
	acute rehal failure				performed?	cor	npletion of cause death?
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certificate rector, page	25. Was case referred to medicel examiner?	TO FORM		26. Place of Deeth (C	heck only one)		
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Funer Hely fill		an: To the best of my knowled On the basis of examination					
Within To the Comple	29b. Signature and title of certifier	end manner stated.	29c. Licen	se number	29d. Date s	igned (Month, i	Day, Year)
1369) -12. A 1 A1	n	216	1574	11/1:	3/00	
1/1	30_Name and address of person who comp	bleted ceuse of death (Item 23	ta) (Type, Print)	10.0	1	1	^
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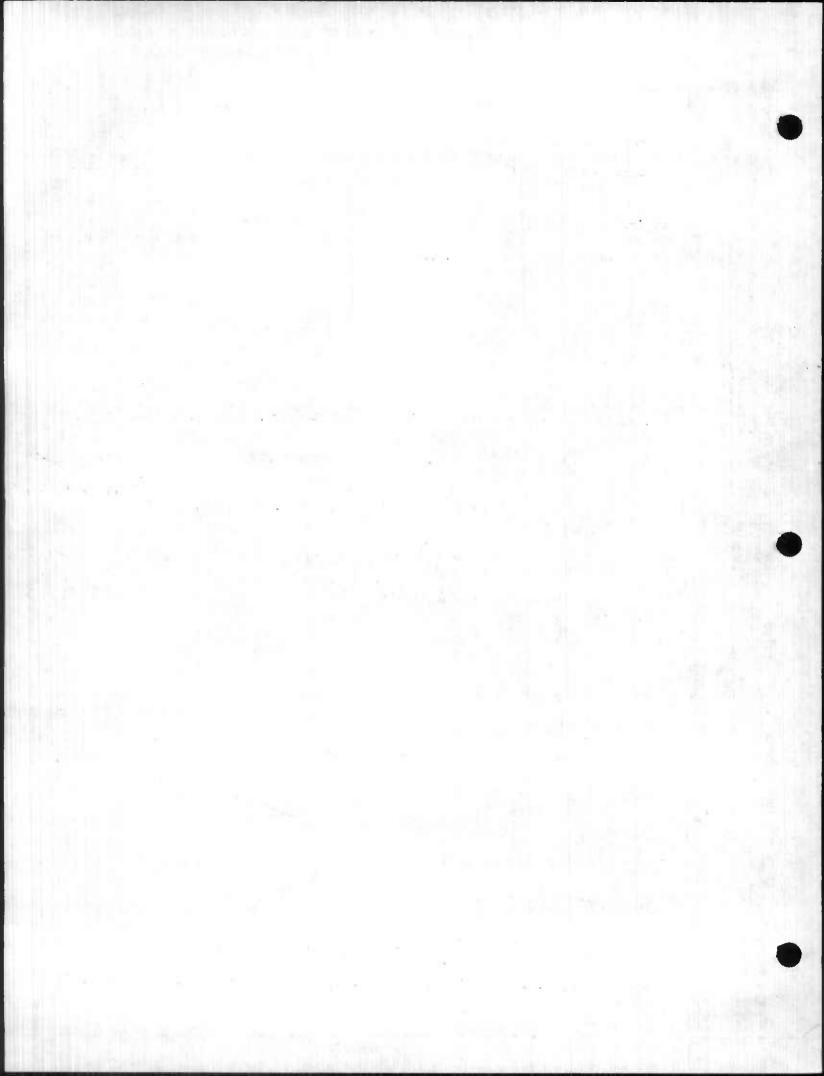
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kaminer	40	Fscility Name (I	f not institution, g	give street and n	number)				4b. City, Town		ation of Death		ity of Death		
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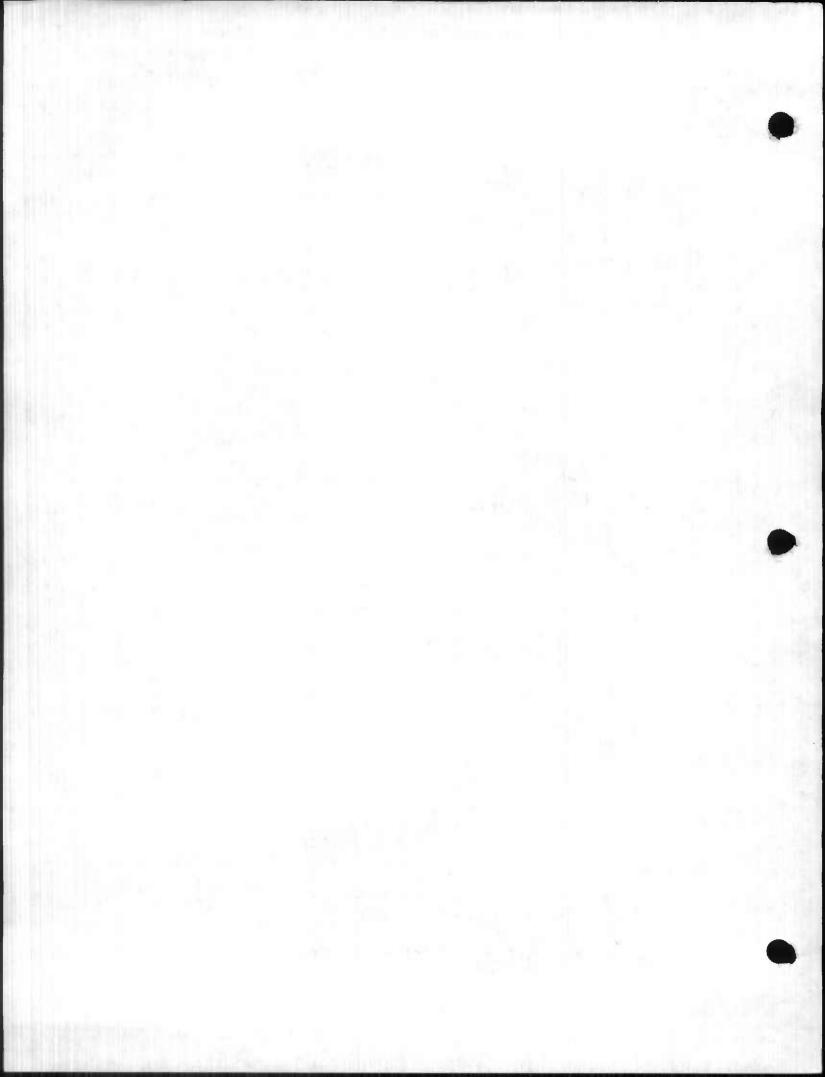
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2. Date of Death THOMAS E. PEREGOY NOV. 13, 2000 9:04 A.M. 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 46 TALISTER COURT WHITE MARSH BALTIMORE If Undar 1 Yaar | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3/16/1951 5. Social Security Number 9. Birthplace (State or Foreign 7. Aga (In yrs. last birthday) ₩ M 2 F Days Hours Yrs. 217-54-3771 MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE WHITE MARSH 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 46 TALISTER COURT 21237 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Datas: Was Decedent of Hispanic Orlgin? (Specify Yes or No-lt Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amaricen Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10TH GRADE TRUCK DRIVER TRUCKING CO. 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) WALTER PEREGOY MAXINE MINKS 19a. Intormant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE, MD 21206 BROTHER-IN-LAW 6117 MOYER AVENUE GENE BROWN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State

11/17/00

THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD

Physician /Medical Examiner

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Physician

/Medical

Examiner

10a. State

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Funeral

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Completed

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Funeral

Director

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Baltimore,

Box 68760

P.O.

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Division

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Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last cal

Immediate Cause (Final disease or condition resulting In death)

1 Burial 2 Cremation 3 Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Servica Licensee

and Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Due to (or as a consequenca ot):

METRO CREMATORY, INC.

22. Name and Address of Facility

21286 Approximate Interval Between Onset and Death

CATONSVILLE, MD

23b. Did tobacco use contribute to the cause of death?

Due to (or as a consequenca of):

Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dua to (or as a consequance of):

1 Tas 2 No 3 Probably 4 Unknown p 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? 1 Yas 2 Ho 1 Yes 2 No 25. Was case reterred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpaliant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending Investigation 1 Natural
2 Accident 1 Yes 2 No 6 ☐ Could not be determined 3 Suicida 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - Al home, farm, streel, factory, office building, etc. (Specify) 4 Homicide

29a. Certifier (Check only one)

Tertifying Phyelclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Data signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D18487

11/13/00

MYO THANI 31. Date tiled (Month, Day, Year)

HOSPITAL 32. Registrar's Signature

6830

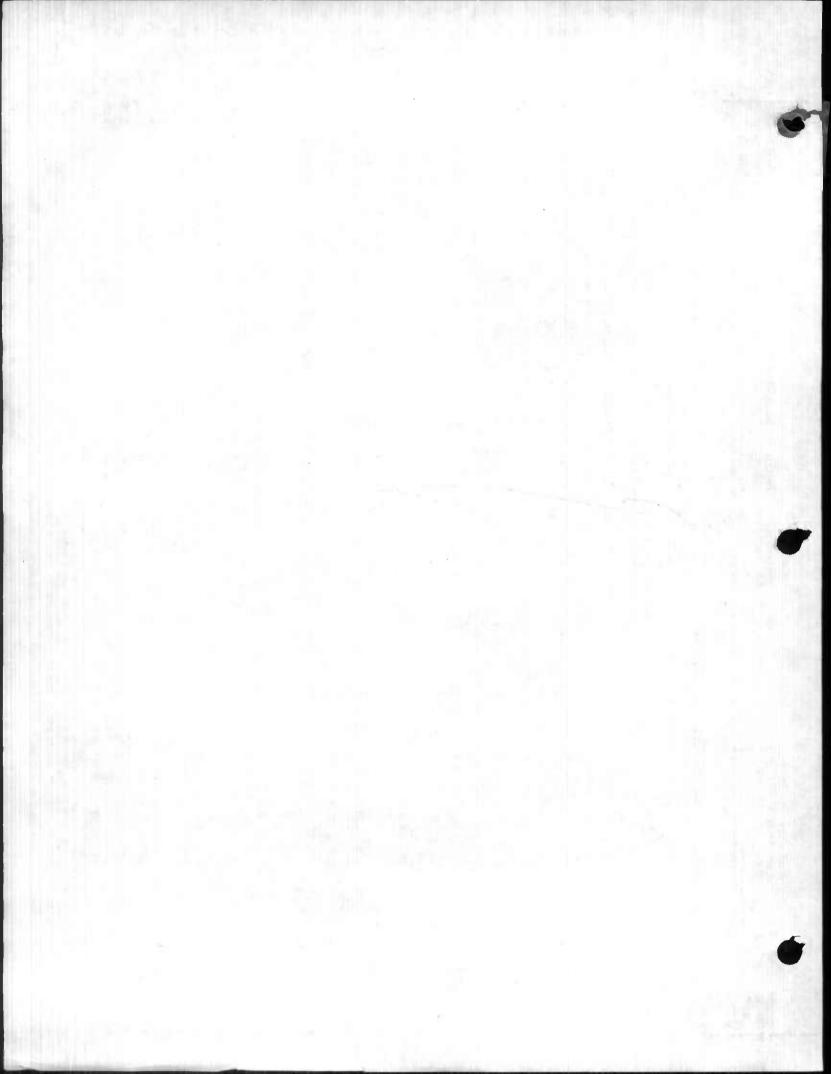
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State Registrar

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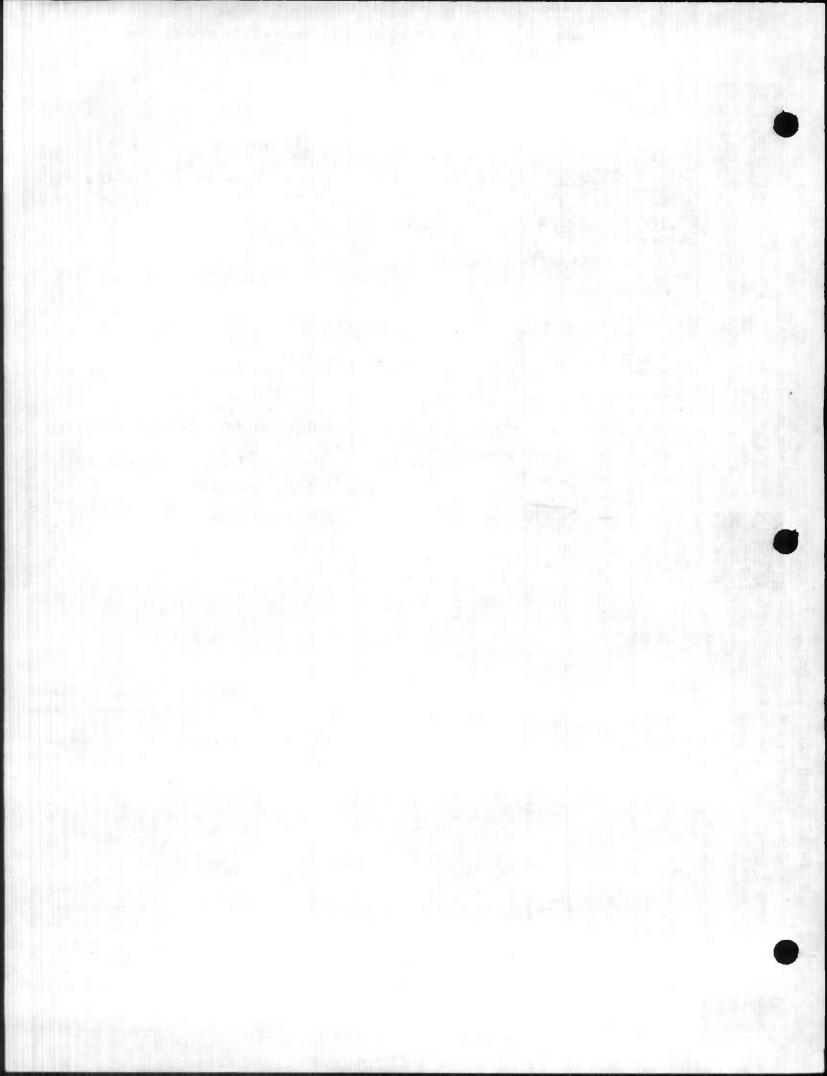


State of Maryland / Department of Health and Mental Hygiene

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	Certificate of Death	Re	g. No.	30421
Physician	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Ye	3. Time of Death
/Medical	Dennis Peaton	MON	13 200	00 7:2214
§ Examiner	4a Facility Name (If not institution, give street and number) 4b. City, Town, or Li	ocation of Deeth	4c. County of I	Death
2	Lorian Nursing Home Balt	more	N.	/A
Funeral	5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs. 12 - 5 - 5 - 5 - 5 - 5 - 6 - 7 - 7 - 7 - 7 - 7 - 7 - 7 - 7 - 7	8. Date of Birth Month, Day,	Year) 9.	Birthplace (State or Foreign Country)
Director	Usual Residence of Decedent	12-26	-54	Maryland
pur Man	10a. State 10b. County 10c. City, Town or Location		Establish Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of	10d. Inside City Limits
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ther death with the Mo r Herrs 23a or 23a-4 in Inter must be notifie Funeral Directo	600 N. Wolfe Street 21205		00	SA
Canal Canal	11. Merital Stetus 12. Wes Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-		American Indian,
	1 Never Married 2 Merried 1 Yes 2 No	rican, etc./		White, etc.
Eric By	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		Specify:	Black
to be tiled within 72 ho ental Hygiena had other than "natur to event, the Medical o Be Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work	ring	16b. Kind of Busin	ess/industry
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other other the	17. Father's Name (First, Middle, Last) 18. Mother's Nam	o /First Middle A		ruction
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nt of or or or	1 PRurial 2 Cramation 2 Personal from State cemetery, crematory or other place)	1 1		
Thursday,	4 Donation 5 Other (Specify) Voshell Memorial Garden 1 21. Signature of Funeral Source 1	1/20/2000	Baltimo	Re, MID
Depa mpo mpo any l	Hari P. Close	Funenal	Senvice	2, P.A.
-	709 Tessier.	Street, 1	Balt. M	291-10512 O
	23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac shock, or heart failure. List only one cause on each line.	or respiratory arre	ost,	Approximate Intervei Between Onset and Death
Physician /Medical	Immediate Cause (Final			
Examiner	Immediate Cause (Final disease or condition resulting in death) a. HIV (NFector)			ZYRS
5	Due to (or as a consequence of):			
ficate be executed I physician and Is the burlal-trensit	b			
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rate be executed thysician and the burial-transit dical Examir	Cause (Disease or Injury that initieted events Due to (or as a consequence of):			
as the	resulting in death) Last			
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iries that the death certisioned by the attending to be detached for use a d by Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i.	23b. Did to	bacco uae contri	bute to the cause of death
by the stach	Weight loss, esoplasités	1 🗆 Ye	8 2 No 3	☐ Probably 4 ☐ Unknow
gned be de	Weight (oss, esophagetis		/	
Attending Physician: The lew requires that the death certificate be executed acrosable. Acrosable. Solution of the second of the second of the attending physician and by the funeral director, page 2 should be detached for use as the burlat-trensification: To Be Completed by Physician/Medical Exami		24e. Was er perform	n eutopsy 2 ned?	4b. Were autopsy findings svaitable prior to
as be 2 sh			TALL OF	completion of cause of death?
The page		1 ☐ Ye	s 2 No	1 ☐ Yes 2 No
tysician: The lew is certificate has to director, page 2 s	25. Was cese referred to medical 26. Place of Deer examiner?	th (Check only on	е)	
hysic his ce il dire	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	ome 5 Reside	nce 6 Other (Specify)
ng Phi filer thi ineral	27. Manner of Death 1 Natural 5 Pending 28a. Dete of tnjury (Month, Day Year) 28b. Time of tnjury Work? 28c. tnjury at tnjury Work?	28d. Describe ho	w injury occurred	
ending.	2 Accident Investigation M 1 Yes 2 No			
re Att	3 ☐ Suicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)	28f. Location (St. City or Town		or Rural Route Number,
Ce led in Ce				
To the Hospital or Attending Philip 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification:	29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur			
Med apple	one) and manner stated.			
4 × 5 8	29b. Signature and title of certifier Marthew (< Whobber D 45757		9d. Date signed (A	
1	Martin (Wolebrey D45757		N.20 /	5, 2000
NXV	30. Name and eddress of person who completed ceuse of deeth (Item 23a) (Type, Print)	4		
	MATTHEW MCNABNEY 5505 HOPKINS BAYVIEW	CIRCLE	BALT	, NO 2122
State	31. Date filed (Month, Day, Year) 32. Registrar's Signeture			
Registrar	NOV 1 6 2000 herens to franks			
MH 16 Rev 6/95	the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s			

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State of Maryland / Department of Health and Mental Hygiene 0 0 3 6 4 2 2

			Certificate of Death	Reg. No.	00766
	Dhusisian	Decedent's Name (First, Middle, Last)	POULLIA	2. Date of Death Month Day Yeer	3. Tima of Death
0	Physician /Medical	BETTLE	PRILLIMAN	November 14,200	
	Examiner	4a Facility Name (If not institution, give street and number)	4b. City, Town, or Lo	acation of Death 4c. County of Dea	
		5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday) If Under 1 Year If Under 24 Hrs.		
	Funeral Director	218 42 0489 10 M 2 AF 54	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Dey, Year) 9. Bir 12 /2 1945	tholace (State or Foreign ountry)
	pa m	Usual Residence of Decedent 10a. State 10b. County 10c. City, T	fown or Location		10d. Inside City Limits
	with the Maryland a or 28a-f show De notified at		BALTIMORE		12 Yes 2□No
	23a or 2 unit be no	1214 EAST FEDERAL STREE		10g. Citizen of What Co	
5-0020	hours after death v ural", or thems 23s	11. Marital Status 1 Never Merried 2 Married 1 Never Merried 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes, 2 No It Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Speif Yes, specify Cuben, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	acity Yes or No- Rican, etc.) 14. Race - Am Black, Whil	
21215-0	ed within 72 ho ygiene. wr than "naturn it, the Medical It, the Medical	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of works life. DO NOT use retired)	16b. Kind of Business	/Industry
		17. Father's Neme (First, Middle, Last)	HOUSE WIFE	(First, Middle, Meiden Surname)	
land	Mental H Mental H irked off ific evar	- Wales as RD wood		iA ROSS	
Maryland	alth and N 27 is main or trauma		19b. Mailing Address (Street end Number or Rural 1214 E Feograd State	al Route Number, City or Town, State.	
Baltimore,	Pages 1 a ent of Hei nt: If Nem y or othe	18 Buriel 2 Commetion 3 Demoved from State	a of Disposition (Name of letery, cremetory or other place) son fund Veterns (Emekry 1	Dete 20c. Location - City or	
Balti	pemit. Pa Departmen Important any injury pace.	21. Signature of Foneral Service Licensee		PATERS FUNERAL S	ERVICE
r		23a, Part1. Enter the disease, or complications that caused the death.			Approximate
	Physician	23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.			Onset and Death
	/Medical	Immediate Cause (Final disease or condition	breast cancer		8 months
	Examiner	Due to (or as	s a consequence of):		1 0 MOVINS
	P # =	- Acute renal	failure		4 days
	be axecuted ician and buriel-transit	Sequentially list conditions, if any leading to immediate	s e consequence of):		
,60	e cia	Ceuse (Disease or injury	nic renal failure		15 years
x 68760	= 02	resulting in deeth) Last	s e consequence of): t narcotic excess upon admi	ssion	4 days
Вох	e attendir of for use				to the course of death 2
0	and by the detached detached	Pert II. Other significant conditions contributing to death but not resulting		23b. Did tobacco use contribut	
٥,	signed to be det	Diabetes Mellitus Sprenal tran	splant x3 (185,190,198)	10100 10100 101	
cord	been should	Hypertension For chronic	crenal failure	24a. Was an autopsy performed?	Were autopsy findings aveilable prior to completion of cause of death?
al Re	ilcien: The law certificate has rector, page 2 Be Comp	Atrial Fibrillation Possible pul	monary emboli	1□ Yes 2₺No	1□Yes 2ENo
Zi.		25. Was case referred to medical examiner? 1 Yes 22 No Hospital: 1 Propagation 2 ER	Other:	h (Check only one)	ne#ul
Division of Vital Records,	After this or tuneral dire	27. Manner of Deeth 1 PNatural 5 ☐ Pending (Month, Dey Year) 28a. Date of Injury (Month, Dey Year)		me 5 Residence 6 Other (Spe 28d. Describe how injury occurred	вспу)
Divisi	s after death. at Director: Alter to at the country of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the teneral of the tenera	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, fectory, office	28f. Location (Street and Number or F City or Town, Stete)	Rural Route Number,
	Hospi Hospi	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle control on the basis of examination and manner stated.			
	Med Med	29b. Signature and title of cartifier	29c. License number	29d. Date signed (Mon	nth, Day, Year)
	-1	1/2/ Sant 118	RES-000	November,	14, 2000
-	VA	30, Name end address of person who completed cause of death (Item 23	,	1,0000,000	1/2000
	1)10	Kavita V. EKNST, M.D. Johns Hopkins Hospi	Hal, Dept. of Medicine, 1830	E. Monument Street,	Baltmore, M.D.
	State Registrar	31. Data filed (Month, Dey, Year) NOV 1 8 2000 32. Registrar's Signatur	B Land	1	or majority of PET

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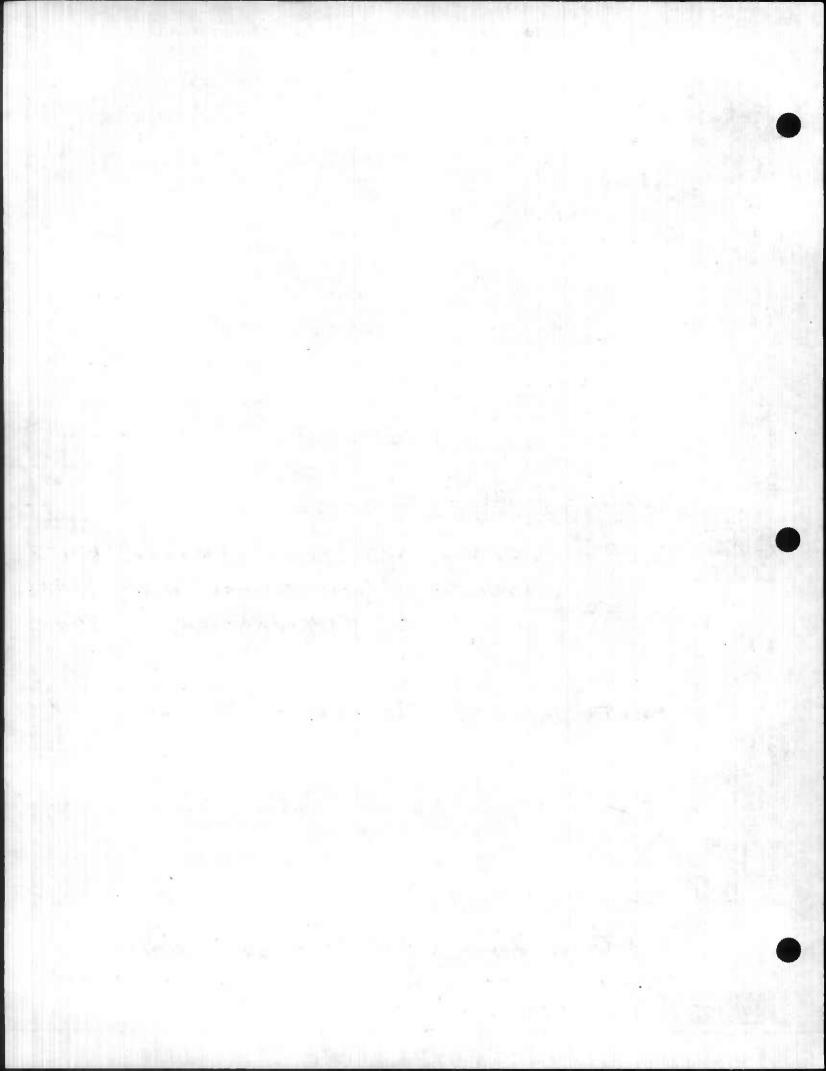
State of Maryland / Department of Health and Mental Hygiene

36423 Certificate of Death

								Cei	lineale	JI L	Jeani		R	eg. No.			
П	Physicia: /Medica	n		D. Passe									Month Ovember	Day	.000°	-	of Death; 15 PM
	Examine	4		If not institution, gi						4	b. City, Town,		tion of Death		y of Death		
				Home of (-	If I lades 4 Va		Rockvi				gomer	•	
П	Funeral Director		Social Security N	432	Sex 1□M 2፟M F		(In yrs. last bii 38	Yrs.	If Under 1 Ye Months Da		If Under 24 Hours 1	Min.	Date of Birth (Month, Day) Peb 28,	Year) 1912	9. Birthp Coun CA	lace (Sta try)	ate or Foreign
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	ath with the Marylar 23e or 28e-f show	CTOL	MD	Mont	gomery				ille								Yes 2∭No
	5 2 5	1	0e. Street and Nu						10f. Zip Cod				1	0g. Citizen of		try?	
	23	<u>a</u>	6105 Mo	ntrose R							0895			USA 14. Race - American Indian.			
36		by Funeral Director	Marital Stetus Never Merr Widowed	ried 2 Married	12. Wes De Armed F 1 Tes If Yes, C Year or	orces? 2 1 No Sive			Vas Decedent Yes, specify C			7 (Speci Juerto Ri	ry Yes or No- can, etc.)	Ble	ce - Americ ick, Whita, fy: whi	etc.	,
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₫,	- 5967	e l		(First, Middle, Last							18. Mother's	Neme (First, Middle, I	Maiden Suma	me) ui	nk	
aryla		19a. Informant's Name/Relationship (Type, Print) 19b. Ma							ailing Address (Street and Number or Rural Route Number, City or Town, State, Zip					Code)			
_			Elizabeth Tevelow/niece 14 20a. Melhod of Disposition 20b. Place of D											20878	3		
ore		2	1 ☐ Buriel 2	position Cremelion 3 [5 Other (Speci		n Siele			sition (Name or netory or other		e)		Dete	20c. Location	- City or To	wn, State	2
Balti			21. Signature of Fu	uneral Service Lice	nsee	Dire	ctor	St	Name and Adate And	at	omy Boa		655 W	. Balti	imore	Stre	eet
F	Physician		23a. Partt. Entert shook, or hea	the disease, or con an failure. List only	nplications that one ceuse on	caused in	the deeth. Do		altimor			1201 rdiac or i	respiratory err	est,		Approxi Intervat Onset e	mate Between and Deeth
	/Medical Examiner		Immediate Cause disease or condition resulting in death)	on	a	ON	CEST	CONSEC	uence of): CAPE uence of): H	1	EART	-	FAI	LURI	= 1	400	IRS
		Der			HYDE	TO T	ENC IN	=	CHOS	21	NUAS	cil	40	DICE	ACE	YE	ARC
	nd Irans	Examiner	Sequentially list co	anditions,	b. # // C	70- 70	Due to (or as a	conseq	uence of):	//	2013		11/1	1130	106	/	7.7.
0,			Sequentially list co if any, leading to in ceuse. Enter Unde Cause (Disease or that initiated events	mmediate erlying	. 6	50 8	ENTI	AL	14 7	15	FRT	EN	18101	1/		45	APS
68760,	certificate be executed iding physician and as the bunal-transit	nymedical	that initiated events resulting in death)	Last	С.	D	ue to (or as a	consequ	uence of):				,,,,,				
9 x	5 06	3			d												
0	c 8 3				J.												
0	9 6 6	Physicia	Part II. Other eignit	ficant conditions	contributing to	death but	t not resulting i	n the ur	nderlying ceuse	e giv	en in Part I.		23b. Did to	obacco uae c	ontribute to	the cau	se of death?
<u> </u>	5 60 .	Dy Ph	MUL	T1 11	VFAR	oe.	T "	DE	ME	N	TIA		1 🗆 Y	'ee 2□ No	3 Pro	oably	4 Dunknown
Vital Records,	requires een sign hould be	Completed											24e. Was a perfor	in autopsy med?	av	allable pi	
ec	law r	- 2	T-8					112		Η		_			of	death?	of ceuse
E .	ician: The lay certificate has rector, page 2	5											1 🗆 Y	es 20X No	1[Yes	2□ No
/ita	ysician: is certific director,		25. Was case refer examiner?	rred to medicel							26. Place of	Death (Check only or	16)			
of	00	2	1□ Yes 20	No	Hospital: 1	Inpatier	t 2 ER/O	utpatien		Oth	4 De NUISI		e 5 ☐ Resid			y)	
lon	Attending P ir death. bctor: After th by the funera	ation:	27. Menner of Deat 1 ☑ Naturat 2 ☐ Accident	th 5 Pending investigetion		e of Injun onth, Day	Year) 28b.	Time of Injury	M 28c. 1		yat k? Yes 2⊡No		ld. Describe h	ow injury occu	irred		
5	of or Attendants of in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not to	208. PIG		ry - At home, fa (Specify)	arm, str	eet, factory, off	ice		28	f. Location (S City or Tow		nber or Run	il Route	Number,
	Hospi 4 hou Funer (sky fill		29a. Certifier (Check only one)	18 Certifying Pi 2 Medical Exa	miner: On the		examination ar										se(s)
	within 2 To the comple		29b. Signeture end	title of certifier	0	2	JA JA		29c. Lic	ens	e number	10	2	29d. Date sign	ed (Month,	Day, Ye	ar)
			18	Kener	- Fr	ps	on i	MI	ファ	(058	85		11/14/	00		
		3	O. Name and addr	ress of person who	completed cer	use of de	eth (Item 23a)	(Type,	Print)		100		1	1	pin.	1	-
			STEVE	EN L	1850	N	617	1	MON	1	USE	POTD, ROCKVILLE					
	State	9 5	1. Date filed (Mon	mi, Day, Tear)	32.	PARTIE	r's Signeture	SA.	E n	-	201)						

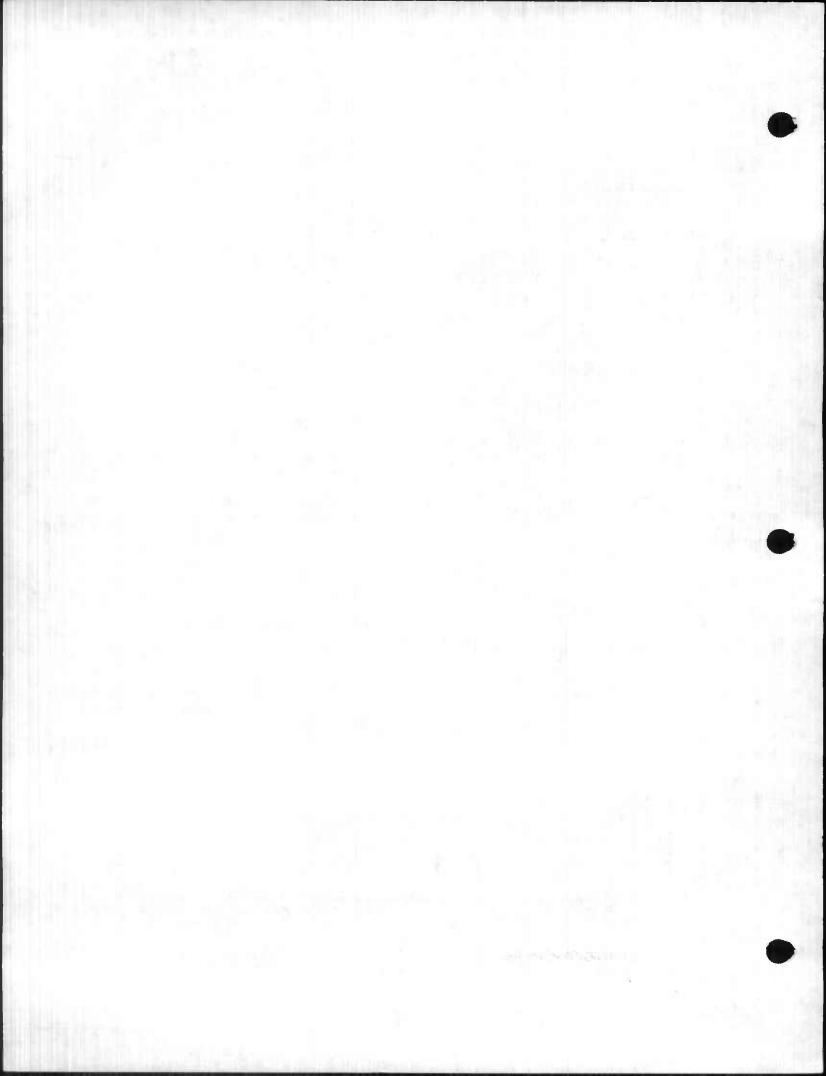
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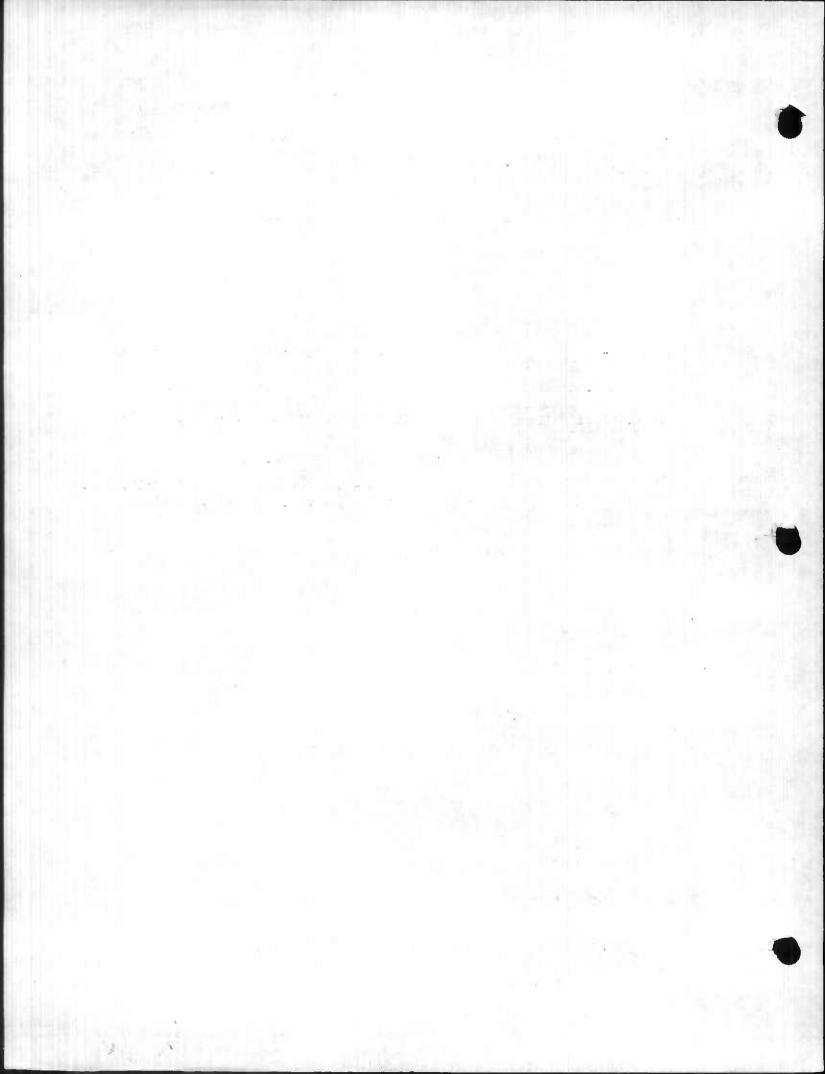


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			Cei	rtificate of	Death	R	eg. No.		7 1 500 1
	1. Decedent's Name (First, Middle, Last)		15.00			2. Date of Deat Month	h Day	Year	3. Tima of Dea
Physician /Medical	SHIRLEY	I.	P	OLANSKY		Novembe		2000	1140 p
Examiner	4a Facility Name (If not institution, give sti				4b. City, Town, or Lo	ocation of Death	4c. County		/A
neral	5. Social Security Number 6. Sex	7. Age (In yr.	s. last birthday)	If Under 1 Year Months Days	If Undar 24 Hra.	8. Data of Birth (Month, Day,	Year)	9. Birthpl	ace (State or For
ector	220-22-8042	M 2X) F 7	3 Yrs.	Working Days	TIOUIS WIII.	MAR.13			MD
11	10a. State 10b. County	10c. C	city, Town or Lo	cation			1//	10	d. Inside City Li
Director	MD N/A		BALTI	7					1 🖾 Yas 2 🗆
al Dire	10e. Street end Number 2500 W. BELVEDERE	AVENUE #1	04	10f. Zip Code	21215	1	0g. Citizen of V		try?
Funer.	11. Marital Status	2. Was Decedent Ever in Armed Forcas?	U,S. 13.	Was Decedent of	Hispanic Origin? (Spo pan, Mexican, Puarto	ecify Yes or No-		e - America	
à	1 Nevar Married 2 Married 3 X Widowed 4 Divorced	1 Yas 2 No If Yes, Give Yaar or Datas:		1 ☐ Yes 2 No		nicari, acc.)	Specify	7.77	HITE
eted	15. Decedent's Educa (Specify only highest grade of		(Giva	dent's Usual Occu	during most of work	ing	16b. Kind of Bu	usiness/Ind	lustry
Compl	Elementary/Secondary (0-12)	College (1-4or 5+)	HOMEM	DO NOT use retire AKER	90)		OWN H	HOME	
BeC	17. Fathar's Nama (First, Middle, Last)				18. Mother's Name	e (First, Middle, M			
0 8	PHILIP		LEVIN		KATIE			ROSE	NBERG
	19a. Informant's Name/Relationship (Type	e, Print)	19b. Mailir	ng Addrass (Stree	t and Number or Run	al Route Number	City or Town,		
	KAREN KLEIN / DA	UGHTER	1221	l VELVET	HILL DRIV	E - OWI	NGS MII	LS, I	MD 2111
6 40	20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Real	moval from State	cematery, crer	natory or other pla			20c. Location -		
	4 Donation 5 Other (Specify)				CEMETERY 1	1/14/00	ROSED	ALE,	MD
9	21. Signature of Funeral Service Licensee	The -		2. Nama and Addr	ass of Facility SOI TERSTOWN F	LEVINS			
	23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the de	1						Approximate Interval Batwee
ian cal	Immediate Cause (Final disease or condition	Sepsis							Onsat and Dea
ner	resulting in death) a.	Dua to	(or as a consac		771-75-				
Examiner	b.	Right Hip W	(or as a consec					1	
cal Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.		(or as a conseq						
use es the bur	rasulting in death) Last	Dua to	(or as a conseq	darica ory.					
Physician	Part II. Other significant conditions contr	ributing to death but not re	esulting in the u	nderlying cause g	iven in Part I.	23b. Dld to	bacco use co	ntribute to	the cause of o
detached y Physic						1 🗆 Y	es 2 No	3 Prot	pebly 4 □ Un
, page 2 should be de Completed by F						24a. Was a perform	n autopsy ned?	ava	era autopsy find ailable prior to mpletion of caus death?
Comp						1 D Y	es 2X No	10	Yaa 200 No
	25. Was case referred to medical				26. Place of Deat			,,,	3 100 220 110
To Be	eveminer?	spital:	☐ ER/Outpatier	nt 3 DOA O	ther:	ome 5 Reside		er (Specifi	v)
	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Data of Injury (Month, Day Year)	28b. Time of Injury	f 28c. Inju		28d. Describe h			,
Certification:	3 Suicide 6 Could not be detarmined	28e. Place of Injury - At building, atc. (Spec	home, farm, str cify)	reet, factory, office		28f. Location (Si City or Town	treet and Numb n, State)	ber or Aura	l Routa Numbe
completely filled Medical Ce		clan: To the best of my kr er: On the basis of axamir and manner stated.							
d wo	29b. Signature and title of certifier			29c. Licer	nsa number	2	9d. Date signe	d (Month,	Day, Year)
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10	30. Name and address of person who com	pleted eause of death (Ite	am 23a) (Tuna	Prim)	()		NUNE	Me	1 10,00
	William Krimski	1 2401	Wes	St Be	elvedes	eHV	2.30	Him	ore 21.
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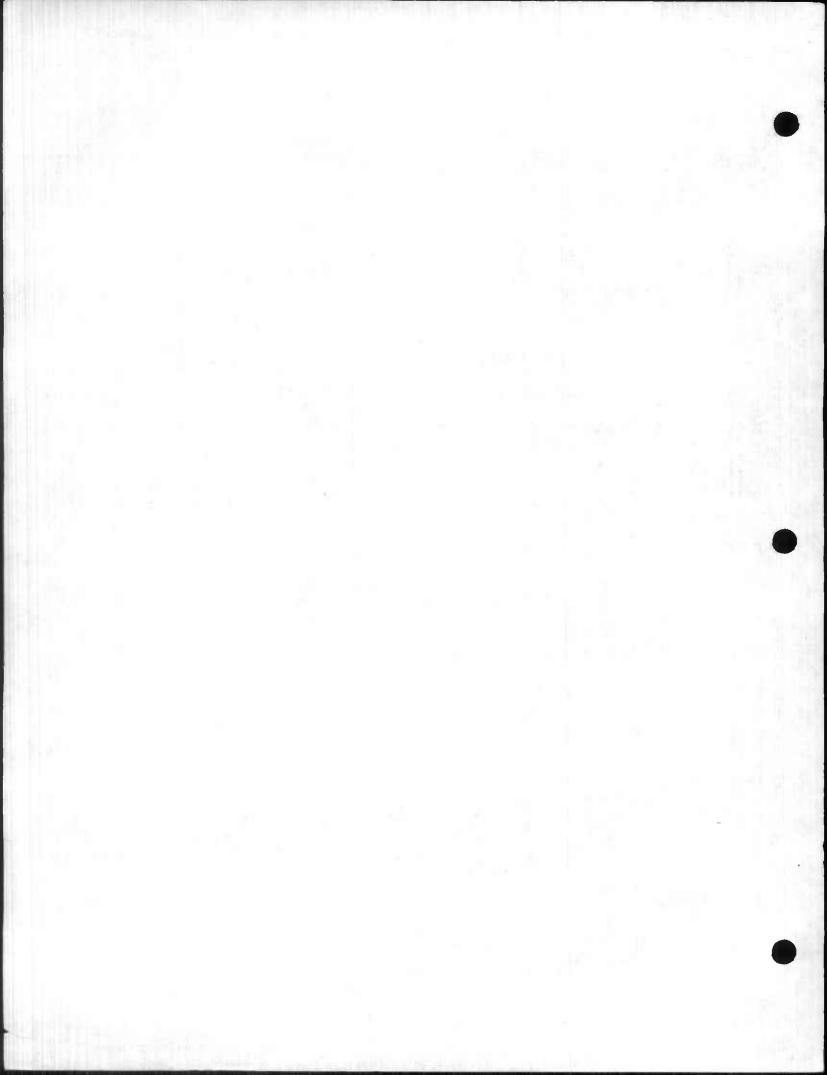
	1, Decede	nt's Name (First, Middle, L	ast)	- 00		Death	2. Data of De			3. Time of Death
Physician			Audrey	Elaine	Pugh		Month Novem	ber 10,2	Year 2000	2:30 PM
/Medical Examiner	4a Facility	Name (If not institution, g	ive street and number)			4b. City, Town, or L				
		point Nursi			T WILL A LAW	Eastpo			Ltimo	
Funeral Director	220-	12-7495	1 TH 0 M C	e (In yrs. last birthday 74 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Feb. I	6,1926	9. Birth	place (State or Foreign (IV) Carolina
B m	10a. State	dence of Decedent 10b. County		10c. City, Town or L	ocation				1	0d. Inside City Limits
to to	Maryl	and Balt	timore	THE ST		Edgemere				1 ☐ Yes 2 🔀 No
natural; or from 23a or 28a-f ahow and Examiner must be notified at	10e. Stree	and Number			10f. Zip Code			10g. Citizen of V		
23a	2	127 Lincoln	Avenue			21219		United S		
al; or items 23a or 28a-f ahow Examples must be notified at by Funeral Director		Status ver Married 2 Married dowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yas, Giva Year or Dates:		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 No	Hispanic Origin? (Sp an, Maxicen, Puarto Specify:	pecify Yas or No Rican, etc.)		k, White,	etc.
"natural".		15. Decedent's	Education	16a. Dece	edent's Usual Occup	pation	kina	16b. Kind of Bu		dustry
Completed	Element	(Specify only highast g ary/Secondary (0-12)	College (1-4or	///e.	DO NOT use retire	during most of work d)	(iii)	A T &		
Co	17.5====	1 Years s Name (First, Middle, Las	41	Tel	Lephone O	perator 18. Mother's Nam	o /First Adiddto			tions
To Be Comp		aham R. Cari						ine Johr		
other traumatic event,		nant's Name/Relationship		19b. Mail	ling Address (Street	and Number or Rui				Code)
100	Gail	W. Fleming	(Daughter)	250	01 Eugene	Avenue	Edgemer	e, Maryl	land	21219
g		d of Disposition		20b. Place of Disp cemetery, cre	osition (Name of ematory or other pla	(Ce)	Date	20c. Location ·	City or To	own, State
5		urial 2 Cremation 3 onation 5 Other (Spec		Bel Air	Memoria	1 Gdns. 1	1/14/20	00 Bel	Air,	Maryland
any inj	1	ure of Funeral Service Lic	ensee		22. Name and Addre	ess of Facility Funeral	Home of	Dundalk	, In	C.
Important: If I any Injury or DRGs.		e. C.	(and	0 1	7922 Wise	Ave. Du	ndalk,	Maryland		222
	23a Part shoc	. Enter the disease, or co	mplications that caused y one ceuse on each li	the death. Do not er	nter the mode of dyi	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
cian lical iner	tmmediate disease of resulting in	Cause (Final condition n deeth)		UTE RE	equence of):				1	DAYS
Examiner			b. AR7	ERIOS		TIC HEI	AKT D	ISEASE	-	4EARS
Exar	Sequentia if any, lea	lly list conditions, ling to immediata iter Underlying sease or Injury		Due to (or as a conse	equence of):				i	
s the bur	THE THE PRINTER	sease or Injury ed events in death) Last	C	Dua to (or as a conse	equence of):					
d by the sttending etached for use a Physician/Me		F-12 - 12 2 3	d			400			1	
sicia	Part II. Oth	er significant conditions	contributing to death b	ut not resulting in the	undarlying cause gi	iven in Part I.	23b. Dld	tobacco usa co	ntributs t	o the causs of death?
d be detached for use			TROK				10	Yes 211 No	3 Pro	bebly 4 Unknown
should leted		Ξ	PIABE	TES M	ELL!	TUS	24e. Was perio	an autopsy ormad?	a\ cc	fare autopsy findings vailable prior to empletion of causa death?
0 0								Yes 2 DINO	1	☐ Yes 2☐ No
Page 2							10	Tes ZLIPNO		
ector. page 2 Be Comp		ase referred to medical				26. Place of Dea				
To Be	25. Was c examin	er? s 2 No		ent 2 ER/Outpatie	ent 3LI DOA	her: 452 Nursing H	th (Check only	one)		(y)
To Be	25. Was c	er? s 2 No pf Deeth tural 5 Pending cident investiget sicide 6 Could not	28a. Date of Inju (Month, Da	y Year) 28b. Tima Injury	of 28c. Inju	her: 4.69 Nursing H iny at ork?] Yas 2 □ No	ome 5 Resi	one) idence 8 Oth how injury occur	red	
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n by the funeral director.	25. Was c examin 1 Ye 27. Manne 1 Ma 2 Ac 3 S	of Deeth tural 5 Pending cident investiget idede 6 Could not determine	28a. Date of Inju (Month, Da	y year) 28b. Tima Injury aury - At home, farm, s.c. (Specify) of my knowledge, deaf axamination and/or if	of 28c. Inju M 1 1 treet, factory, office	her: 448 Nursing H iny at ok? Yes 2 No	ome 5 Resi 28d. Describe 28f. Location (City or To	one) idence 8 Oth how injury occur (Street and Numburn, State) cause(s) and me	per or Rur	al Routa Number,
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State of Maryland / Department of Health and Mental Hygiene 36426

amend item	23a,27, 28a,b,c,d,e,f pe	er me G789 11/30/00	y Certificat	e of Death		Reg. No.		1420
Dhualaian	1. Decedent's Name (First Middle, Lest	1 10			2. Dete of De Month		Year :	3. Time of Death
Physician /Medical	NODIE K. KOK	DINSON UK.			Novembe	er 09, 2	000	2230 pm
Examiner	4e Facility Neme (If not institution, give			4b. City, Town, or I		4c. County	of Death	
	1950 Walbrook Ave		t birthday) If Unde	Baltimor		N/A	9. Birtholac	e (State or Foreign
Funeral Director		M 2□ F 3'	7 Yrs. Months	Days Hours Min.	8. Dete of Bird	2.9963	S. Car	Polina
2	Usual Residence of Decedent	100 000	Town and another				1404	Institute Other Limite
teryte at at	10a. State 10b. County	1601	timore				100.	Inside City Limits 1 □ Yes 2 □ No
with the Meryland a or 28s-f show the notified at	10e, Street and Number	Out		Code		10g. Citizen of V	/hat Country	?
Da or at De or	11950 Walbrook	1946.	21	21T		USA		
har death with the Meryls hare 22e or 28e4 sho liner must be notified at Funeral Director	11. Marital Status	12. Was Decedent Ever in U,S. Armed Forces?	13. Wes Dece	dent of Hispanic Origin? (S cify Cuben, Mexican, Puert	pecify Yes or No o Ricen, etc.)	- 14. Raci	- American k, White, etc	
	1 Never Married 2 Married	1 ☐ Yes 2 D No If Yes, Give	1 ☐ Yes			Specify	Olas	K
21215-0020 of within 72 hours at places. The Medical Examp Completed by §	3 Widowed 4 Divorced	Yeer or Detes:	16a. Decedent's Usu	al Occupation		16b. Kind of Bu	siness/Indus	itry
215 Prin 72 Medic Medic	(Specify only highest grad		(Give kind of wo	ork done during most of wor	rking	Tamo		
1 2121 hed within hypiens. ner than nt, the Me		2yrs.	cher			remp		ency
Be system	17. Father's Neme (First, Middle, Last)	1000		18. Mother's Nar	ne (First, Middle,	<i>Maid</i> en Sumam	e)	
To To	, 19e. Informant's Name/Relationship (7)	One Print)	19h Mailing Addres	s (Street and Number or Ru	ural Route Numb	er City or Town	State. Zin Co	ode)
Ma 27 st	Veronica Boone - K	phinson wife	2727 (VIburn Ave	Balto	., MD.	21215	5
Pages 1 a ent of He nt. if Nem ry or othe	20a. Method of Disposition 1 Burial 2 Defenation 3 DE	000	ce of Disposition (Na netery, crematory or	me of other place)	Date	20c. Location -	City or Town	, State
altimo	4 Donation & Other (Specify)	met met	ro Crema	tory i	1-18-00	Catons	Ville,	MD.
Ball Separation of the separation of the separat	21. Signature of Futeral Service Licens	··///	A2. Name e	nd Address of Facility	Funera	1 Hom	e P.A	7.
- 40244	Xmy////	me	2770 F	redhilton Pas	es Bali	10.1 MD	2/2	29
Ph sician	231 Part Little be drawse, or complete hock, or hourt talkire. List only o	ne ceuse on each line.	Do not enter the mo	be of dying, such as cardia	c or respiretory e	rrest,	In	pproximate iterval Between inset and Deeth
/Medical	Immediate Cause (Final disease or condition	NARCOTIC AND CO	CATNE INTOXT	CATTON				
Examiner	resulting in death)	ā	s e consequence ot)					
executed n and iel-transit		b. ————————————————————————————————————					1	100
exacu	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or a	s a consequence of)	34-45				
. Box 68760, death certificate be executed to a strending physician and bot for use as the buriel-transit sician/Medical Examir	thet mitiated events	c Due to (or e	s a consequence of)			-		
S S S S S S S S S S S S S S S S S S S	resulting in death) Last							
P.O. BOX at the death cer d by the attendin etached for use		d					1	
P.O. that the de detached detached	Part II. Other significant conditions con	ntributing to deeth but not result	ing in the underlying	ceuse given in Part I.				he cause of death?
					10	Yes 2LINO	3 Probat	bly 4 Denknown
Records, P he law requires that he has been signed to age 2 should be deter					24a. Was	an autopsy	24b. Were	autopsy tindings able prior to
D s b					HISTOR		of de	oletion of cause
= - 44 0					16	Yes 2□No	101	fes 2□ No
Of Vital I Physician: The this certificate ral director, page Co.; To Be Co.	25. Wes case referred to medicel examiner? 1 ☑ Yes 2 ☐ No	Hospital:		Out.	eth (Check only		40	-1
0 4 5 7	27. Manner of Death	28a. Dete of Injury 2	R/Outpatient 3 D	28c. Injury at Work?		how injury occur		at scene
Attending Isr death. ector: After by the funerilf Catlon	1 Netural 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Dey Year) found: 11/9/00	inipry P ound: M	1 Yes 2,5(No	ULIKITOWIT			
Division of attending P after death. In Director: After the in by the funers Certification:	3 ☐ Suicide 6 🔀 Sould not be determined	28e. Plece of Injury - At hom building, etc. (Specify)		y, office	28f. Location (City or To	Street and Numb		Route Number, rook Avenue
April 6 m	29a. Certifier 1 ☐ Certifying Phy	found: reside		Lat the time, date and class		e, Marylar	nd	
edical	(Check only one) 2K) Medical Exami	ner: On the basis of exemination and manner stated.	n end/or investigation	n, in my opinion, death occi	urred at the time,	date and place,	and due to th	ne ceuse(s)
O NO NO	29b. Signeture end little of certifier	11/ 00		c. License number		29d. Date signe	d (Month, Da	ıy, Year)
1/0	Il Mayore	the shell		O.C.M.E.		Novemb	er 10,	2000
(h)	30. Name and address of person who co	empleted cause of death (Item 2					-1-11	
111	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	111 Pe	nn Street, B	altimore	, Maryl	and 21	201
State Registrar	0.000	o Servas	19 190	orkal				

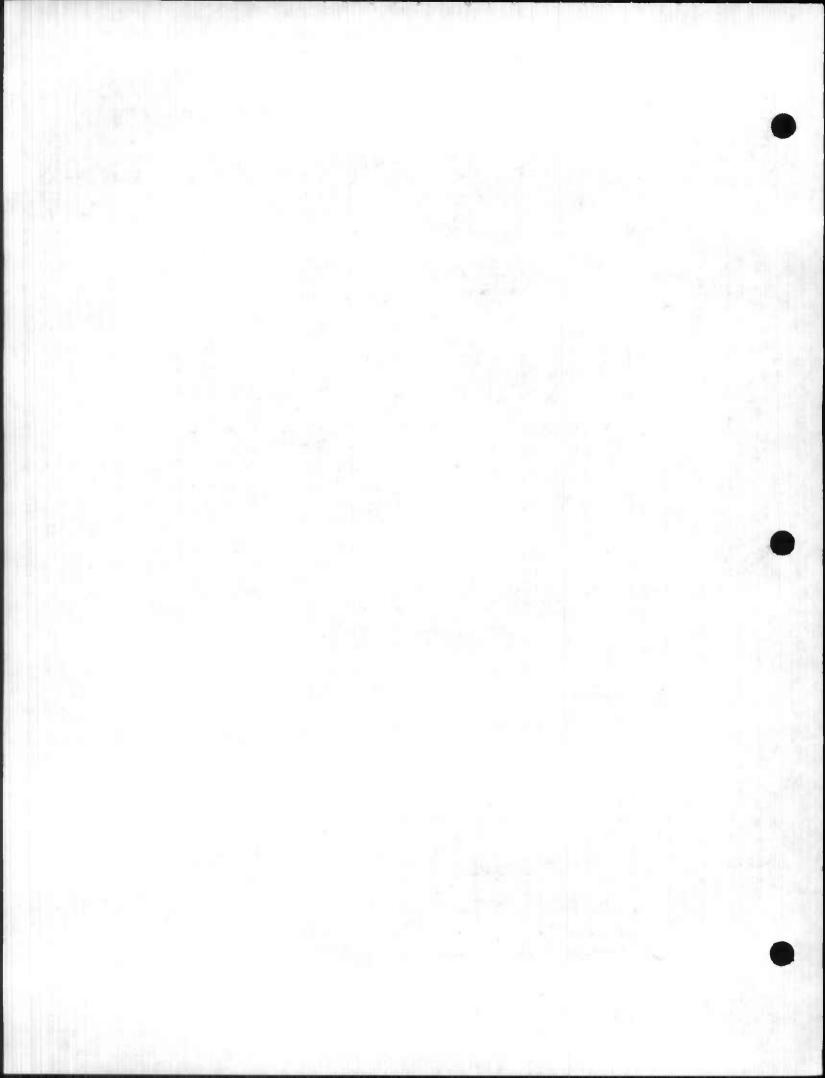
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Nama (First, Middle, Last) 3 Time of Death Month **Physician** SISIA 13, LOIS NOVEMBER 2000 10:14 PM /Medical 4b. City. Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Saint Joseph Medical Center Baltimore Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Dey.
(Month, Dey. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Deys 1 M 200 F 217 34 Yrs SPT- 27 1914 RINANTANIA Director 6298 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow the Medical Examiner must be nothing at 11 Yas 2 No Director BALTIMORE MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 2 PKWY 2.0 .19 3120P 4111 DRTHERC Funeral Hems. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, White, etc. 11. Marital Status hours after 1 ☐ Yes 21© No If Yes, Give Year or Detas: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 natural, or 1 ☐ Yes 2 No P 38 Widowed 4 ☐ Divorced Tilth Completed filed within 72 h Hygiena. other than "natur 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) HOMEMAKER 127RS-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental is marked -HARLUS KLZZW SIOAL 1000 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31015 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 is Department of Health ar important: if Itsm 27 is any Injury or other trau PHILLIP W. KOAD GREEN S BELATR, DARYLAND 20c. Location - City or Town, State BELAIR Nov. 19 20b. Place of Disposition (Name of GRRDING cemetery, crematory or other place) 20a. Method of Disposition Buriel 2 ☐ Cremation 3 ☐ Removal from State HIGHVIZW I SMORIA 4 Ponation 5 □Other (Specify) ~ 2000 FAULSTON 21. Signature of Funeral Service Life FUNZRACHAPEL - BZLAIR, P,A. 22. Name and Address of Facility EVANS 3 DEW PORT DRIVE FOREST IARYLAND Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest shock, or haart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final SEPTICEMIA 18 DAYS disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Examine ADULT RESPIRATORY DISTRESS SYNDROME Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): and physician 68760 BILATERAL PNEUMONIA Physician/Medical Due to (or as a consequence of) the the attending Box d RESPIRATORY FAILURE Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yss 2 No 3 □ Probably 4 □ Unknown signed by Division of Vital Records, py 8 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed'i page 2 1 Yas 20 No 1 Yes 25 No or Attending Physician: Be 25. Was cese referred to medical 26. Place of Death (Check only one) Hospitel: 1 Junpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No 10 this 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred Cartification: After Natural 5 Pending investigation Injury 2 No 2 Accident 1 Yes 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 報 4 Homicide Jo the Funeral I 113. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. edical 29a. Certifier (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signad (Month, Day, Year) 000 30. Name and address of purson who completed cause of death (Item 23a) (Type, Print) FEMY CHHIM, M. D. , 7601 OSLER TOWSON, MARYLAND 21204 31. Date filed (Month. NOV 1 6 2000 32. Registrar's Signatura

DHMH 16 Rev 6/95

State Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Day Year **Physician** 1233 Am **Neil ODorion Roby** November 15 2000 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clarksville Howard 13250 Greenberry Lane If Undar 1 Year 6. Sex 7. Aga (In yrs. last birthday) If Undar 24 Hrs. 5. Social Security Number 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** Days Months 10 M 20 F Hours 48 Director May 6, 1952 220-56-0725 MD Usual Rasidence of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas x2 No Director Clarksville Maryland Howard 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? iner must be r 21029 U.S.A. 13250 Greenberry Lane Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 √ Yas 2 □ No If Yas, Giva 1971 Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian. 11. Marital Status Hygiene. Oher than "natural", or llan ant, the Medical Examiner. Black, Whita, atc. 1 Nevar Marriad 2 Married 1971 1 Yas X No Specify: py White 3 Widowed 4 Divorced Yaar or Datas: 1971 Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) Elemantary/Secondery (0-12) Collega (1-4or 5+)

20b. Place of Disposition (Nama of cematery, cremetory or other place)

All County Cremation Services, Inc.

22. Nama and Addrass of Facility

permit. Pages 1 and 2 should be the Department of Hoash and Mental Hy Important. If hem 27 is manked oth any injury or other traumatic events.

Be

10

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

filled within

Examine certificate be executed physician and s the bunal-trans Division of Vital Records, P.O. Box 68760 Physician/Medicai 88 use 0 detached f signed by I by Completed s certificate has b director, Be 10 this unerai After or Attending after death Director: in by

To the Hospital within 24 hours of To the Funeral Completely filled

State

Registra

Certification: 6 Could not be datarmined 28a. Placa of Injury - At homa, farm, straaf, factory, office building, atc. (Specify) 4 Homicida 29a, Certifier edical 29b. Signature and title of certifier 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) Nicholus

31. Data filed (Month, Day, Year)

25. Was casa rafarred to medical axaminar?

1 Yas 2 No

27. Mannar of Death

1 Natural

2 Accident

3 ☐ Suicida

17, Fathar's Nama (First, Middla, Last)

20a. Mathod of Disposition

Immediata Causa (Final disaase or condition rasulting in death)

Sequantially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last

19a. Informant's Name/Relationship (Type, Print)

4 Donation 5 Other (Specify)

21 Signature of Funaral/Sarvice License

Dr. Thomas O. Roby

Mr. Randolph W. Roby

1 Burian 2 Cramation 3 Removal from Stata

14/48

PATUREUT PKy Columbius MD 21044 32. Registrar's Signatura

28c. Injury at Work?

29c. Licansa number

38500

Jenson

DHMH 16 Ray 6/95

ORIGINAL

Approximate Intervel Between Onsat and Death

Lung Cancer to bone and brain Dua to (or as a consequence of):

Truck Driver

Dua to (or as a consequence of):

1 Inpatiant 2 ER/Outpatient 3 DOA

28b. Time of

Dua to (or as a consequence of):

Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlac or respiratory arrest, shock, or heart tailure. List only one ceuse on each line.

MOU530

Part ff. Other algniffcant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Deta of Injury (Month, Day Year)

Hospital:

5 Panding invastigation

18. Mother's Neme (First, Middle, Maiden Sumeme)

19b. Mailing Addrass (Street and Number or Rurel Routa Number, City or Town, Stete, Zip Code) 4301 Buckskin Lake Dr. Ellicott City, Maryland 21042

11/15/00

Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043

Elizabeth "Betty" Bennet

23b. Did tobacco use contribute to the cause of death? 1 Nea 2 No 3 Probably 4 Unknown

Trucking

20c. Location - City or Town, Stata

Sykesville, Maryland

24a. Wes an autopsy performed?

24b. Wara autopsy tindings available prior to completion of cause of deeth?

1 Yas 2 No

26. Placa of Death (Check only ona)

Othar: 4 Nursing Homa 5 Desidence 6 Other (Specify)

28d. Describe how injury occurred

1 TYas 2 □ No

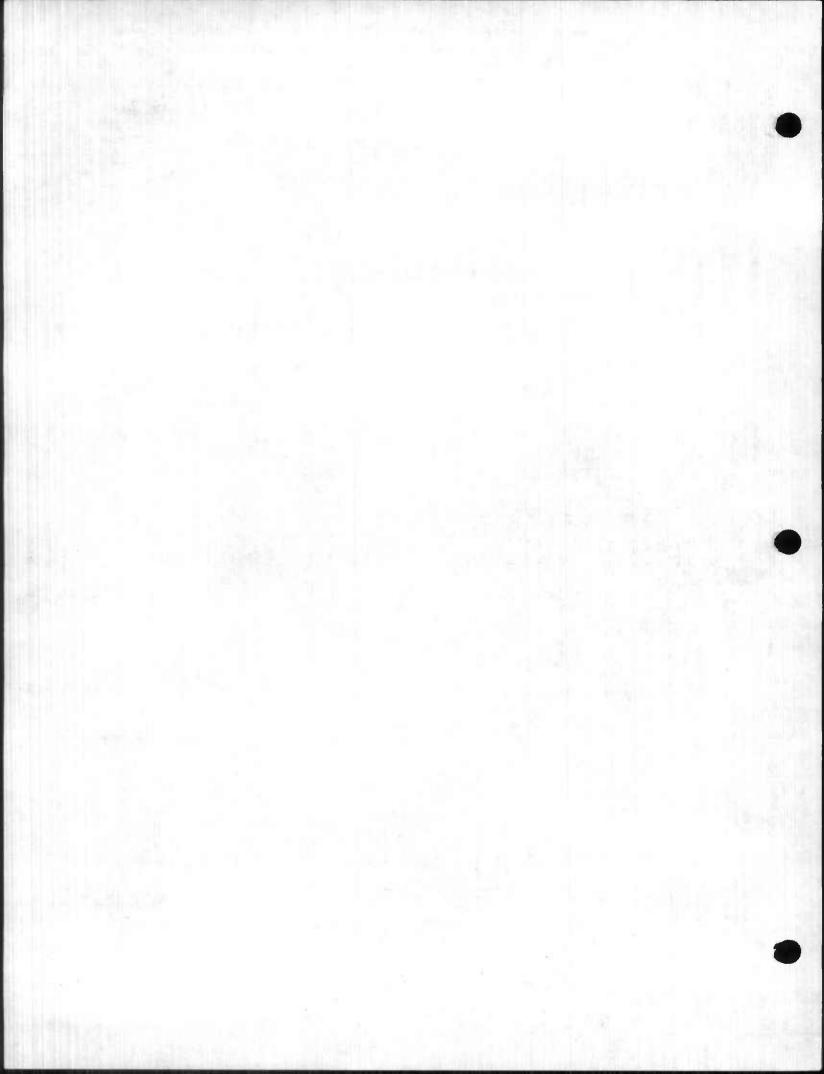
281. Location (Street and Number or Rural Routa Number, City or Town, Stata)

1 Certifying Physician: To the best of my knowledge, deeth occurred at tha tima, deta and plece, and due to tha causa(s) and mannar as stated.

2 Medical Examiner: On the basis of axaminetion end/or investigation, in my opinion, deeth occurred at tha tima, deta end placa, and due to tha cause(s) end manner stated.

29d. Data signed (Month, Day, Year)

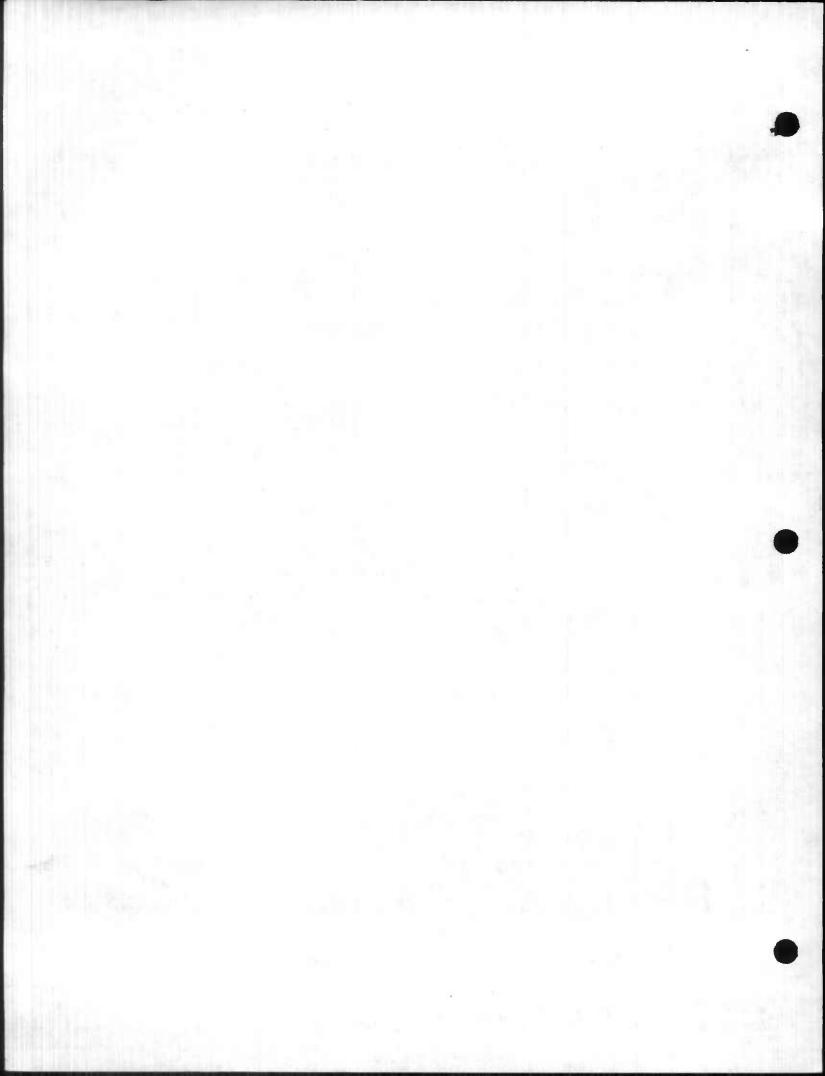
November 15, 2000



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	cation (Street and Nu ty or Town, State)	umber or Rural F	Route Numbe					
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	ne time, date and plac	ce, and due to in	na cause(s)					
Mality Jam- Fennest > D55773	29d. Dale sig	gned (Month, Da	y, Year)					
	November	a/14 7	1000					
30. Name and address of person who completed cause of death (Item 23a) (Type Print)	-0101							
DEGRA M BENSEN-KENNEDY; GOO N. WOLFE STREET	- BAUTIN	nort. 1	MD ZI					



36430 State of Maryland / Department of Health and Mental Hygiene UU Certificate of Death 2. Data of Daath 1. Decedant's Nama (First, Middle, Last) 3. Time of Death Month 10:40 AM EUGENE PAUL SEEFELDT NOVEMBER 8, 2000 4b. City, Town, or Location of Death 4e Fecility Nema (If not institution, give street and number) 4c. County of Death

Examiner **Funeral**

Director

Physician

/Medical

with the Meryland r 28a-f show Director "naturel", or items 23s or adical Evament must be Funerai þ Completed

permit. Pages 1 and 2 should be filed within 72 hours efter death v. Department of Heelth and Mental Hygiane. important: if item 27 is merked other than "naturel", or items 23a enth injury or other traumatic event, the Medical Example mass 100ce.

Baltimore, Maryland 21215-0020 **Physician** /Medical Examiner physician and the buriel-transit The law requires that the deeth certificate be executed Division of Vital Records, P.O. Box 68760. ettending pl for use es t signed by the e his certificate has bill director, page 2 s i or Attending Physician: after deeth. Director: After this certifice funeral 5 To the Hospital or within 24 hours aft To the Funeral Di completely filted in

1743 MAYFAIR PLACE CROFTON ANNE ARUNDEL 6. Sax 1 M 2 ☐ F If Under 1 Yaar 7. Aga (In yrs. lest birthday) If Undar 24 Hrs. 5. Social Sacurity Number Birthplaca (State or Foreign Country) 8. Data of Birth (Month, Dey, Year) Days Hours 68 Yrs. 394-28-7723 May 23, 1932 Wisc Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes 2 No MD Crofton Anne Arundel 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Coda 1743 Mayfair Place 21114 USA 12. Was Decedant Evar in U,S. Armed Forces? Was Dacedant of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indien, Black, Whita, atc. 1 ☐ Yas 2 ☒ No If Yas, Give Year or Datas: 1 ☐ Nevar Marriad 2 Married 1 Yas 2 No Specify: white 3 □ Widowed 4 □ Divorced 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Businass/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) Collega (1-4or 5+) 5 clergyman religion 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Meiden Sumeme) Be Clarence L. Seefeldt 2 Leona T. Jens 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Carol A. Seefeldt/spouse 1743 Mayfair Place Crofton, MD 20b. Placa of Disposition (Name of cemetery, cremetory or other pleca) 20c. Location - City or Town, Stata 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 Donation 5 ☐ Othar (Specify) 22 Name and Addrass of Facility Board Wade, Ronald Director 655 W. Baltimore Street nerry all Baltimore, MD 21201 23. Per 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximata Intarval Batween Onsat end Death Immadiata Ceuse (Final disaasa or condition rasulting in daath) ehydration Due to (or as a consequence of): AND Examiner ANCER 0 Sequantielly list conditions, if any, laading to immadiata causa. Enter Underlying Ceuse (Diseesa or Injury Dua to (or as a consequanca of) Physician/Medical that Initiated evants rasulting in death) Last Dua to (or as a consequanca of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other elgnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 Yas 20 No 1 Yas 2 No 25. Wes case referred to medical axaminar? Be 26. Placa of Death (Check only one) axaminar? Othar: 4 ☐ Nursing Homa 5 Rasidanca 6 ☐ Othar (Specify)
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Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and placa, and due to the causa(s) and manner stated. edical 29e. Certifier

29c. Licansa numbar

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29d. Data signed (Month, Dev. Year)

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PANNA DOLIS, MD

State Registrar 29b. Signatura and titia of cartifiar

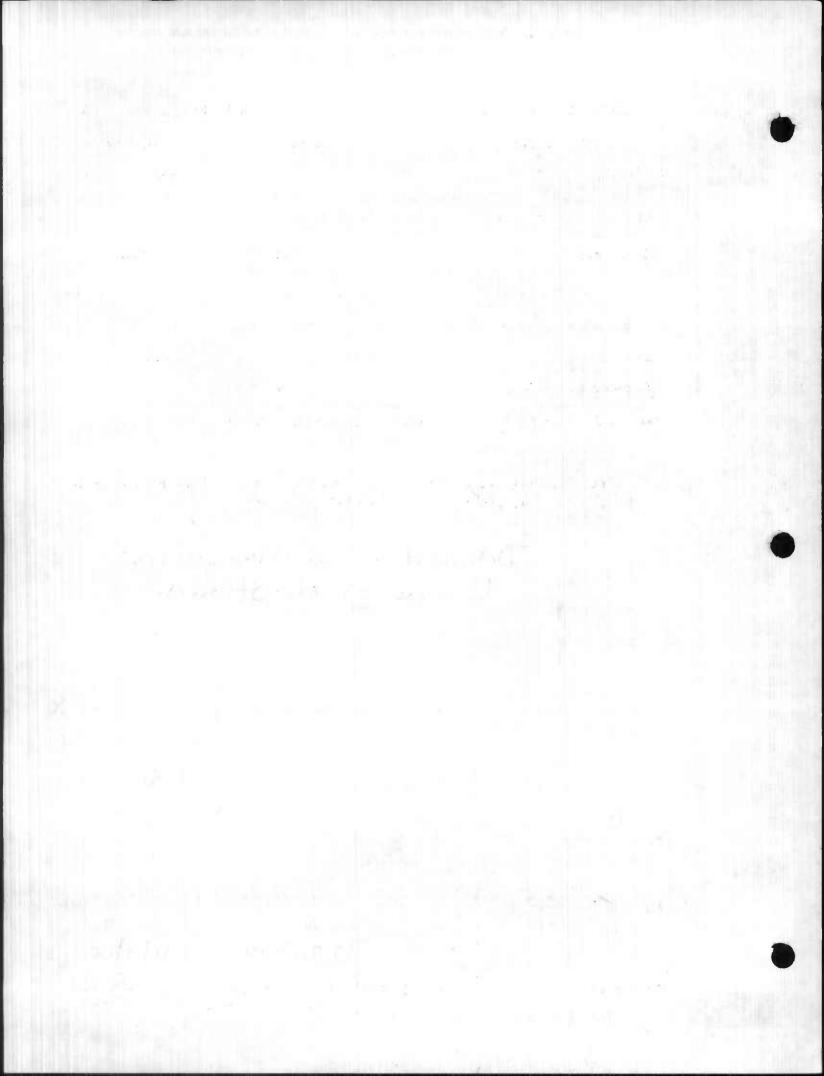
Robert 31. Data filad (Month, Day, Year)

30. Name and address of person who complated cause of death (Itam 23a) (Type, Print)

6 2000

FREEN

32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death **Physician** November 13 2000 1305" cation of Death John Thomas Schwaab /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 6. Sex 1 M M 2 ☐ F If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) July 16, 1949 Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) **Funeral** Days 217-48-9167 51 Director Usual Rasidence of Dacedant 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County MD Dorchester Hurlock 1 Yas 2X No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 105 Webster Street 21643 USA 12. Was Decedent Ever in U,S. Armed Forcas? 1 (X) Yas 2 □ No If Yes, Give Year or Dates: 14. Raca - American Indian, Black, Whita, atc. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Nevar Married 2 Married Specify: White 1 Yes 2 No 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Ò electrician maintenence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Frank G. Schwaab Anna Edwards 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Schwaab/spouse 105 Webster Street Hurlock, MD 21643 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 Donation 5 ☐ Other (Specify) 21 Signature of Euroral Service Licensee Robald S. Wade, Director 25 Name and Address of Facility Board 655 W. Baltimore Street 21201 Baltimore, MD Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, about or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings 24a. Was an autopsy performed? avsilable prior to completion of causa of death? 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 The patient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Medical Certification: To 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural
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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the lime, date and place, and dua to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signatura and file of certifier 29d. Date(signed (Month, Day, Year) o completed cause of death (Item 23a) (Type, Print) 560

Registrar

State

if of Health if Item 27 i

Pages

The law requires that the death certificate be executed

or Attending Physician:

To the I

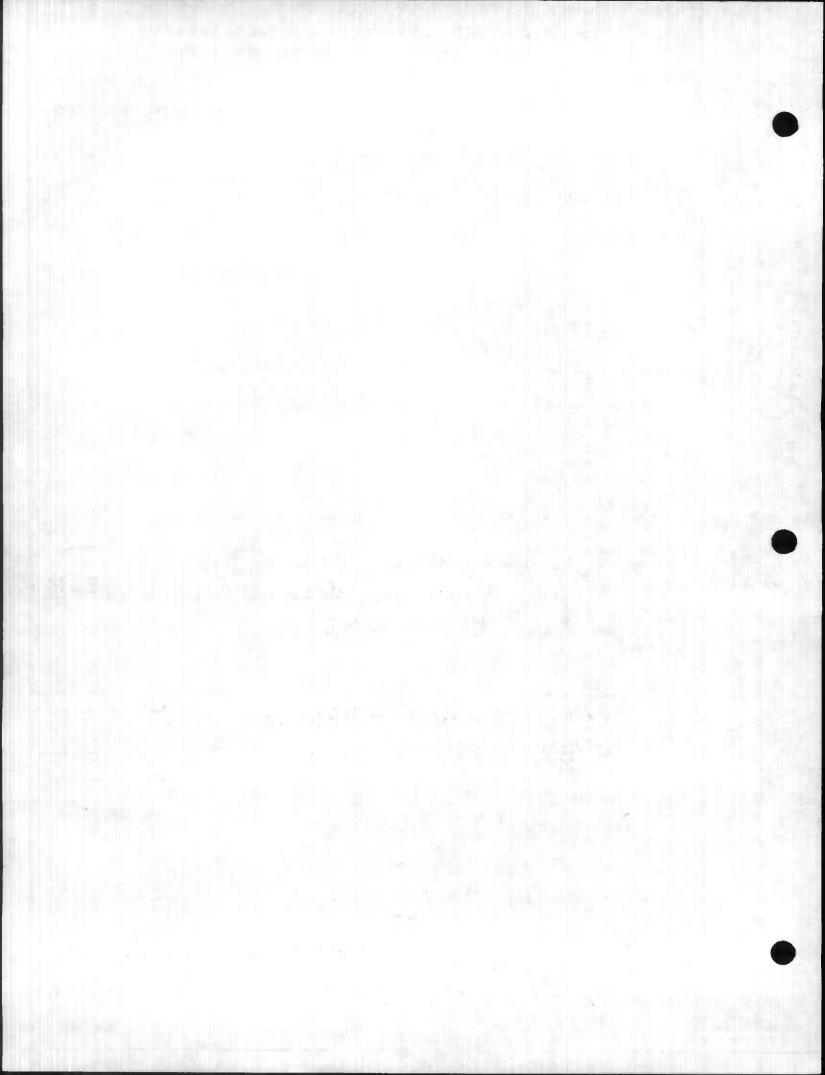
within 24 hours after death. To the Funeral Director: A

Division

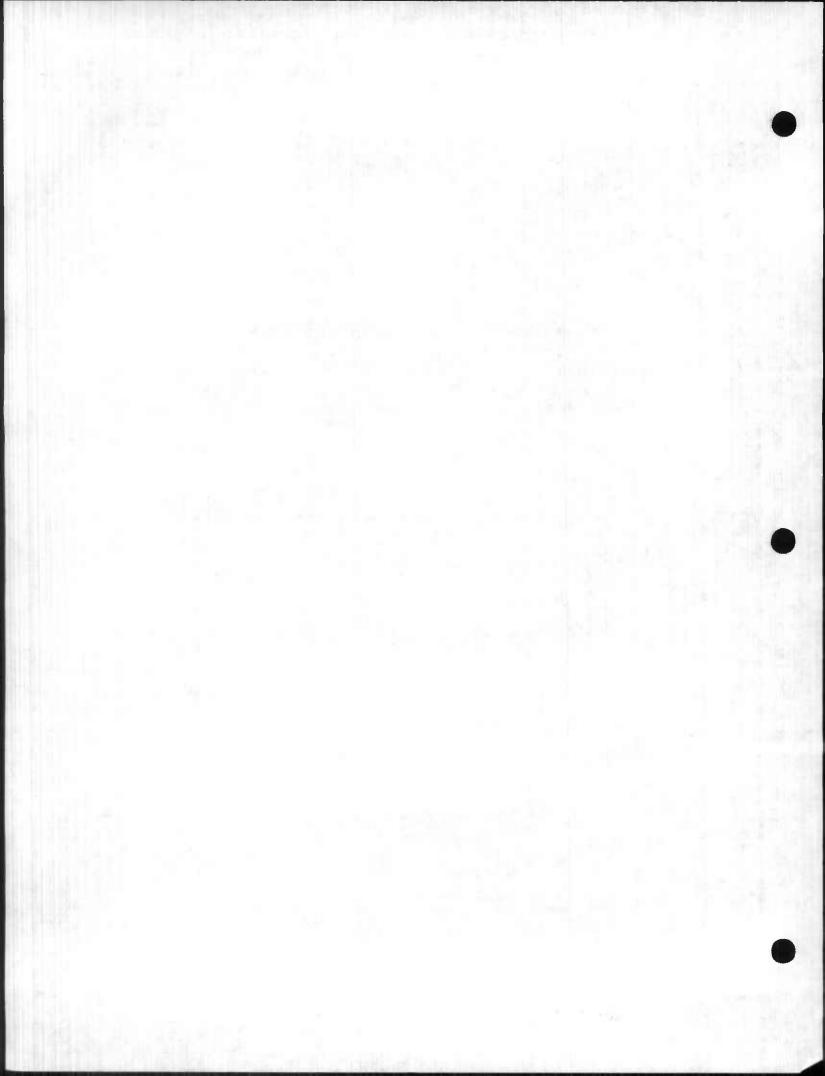
of Vital Records, P.O. Box 68760,

Baltimore,

32. Registrar's Signature



	State of Maryland / Department of Health and Certificate of Death	Mental Hygiene 00 36432						
Physician	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year						
/Medical	Mothryn mow	NOV 13, 2000 1415.						
Examiner	4e Facility Name (If not institution, give street end number) 4b. City, Town, of	or Location of Death 4c. County of Death						
	Harrand Canty General Hospital Colu	mbia Howard						
Funeral	5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) 1 Months Days Hours Mi							
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ylan buid be Mentel mrked o	Lawrence J. Manner	Eleanora T. Madigan						
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	Ms. Terry Green 495 Cardinal Dr. Lusby,							
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DIVISION To the Hospital or Attendent Within 24 hours after deall To the Funeral Director: completely filled in by the Medical Certifical Certifical	29a. Certifier 1☐ **Certifying Physician: To the best of my knowledge, death occurred at the time, dete and pla (**Check only one)							
Nethin	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Dey, Year)						
F > F 0	12/h 2009 D46120	1201 /3 7000						
10	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	.000, 13, 2000,						
	F Declear 10724 Little Petryen.	1 Park Cokumbin dry						
State	31. Date filed (Month, Dey, Year) 32. Registrar's Signeture	, and						
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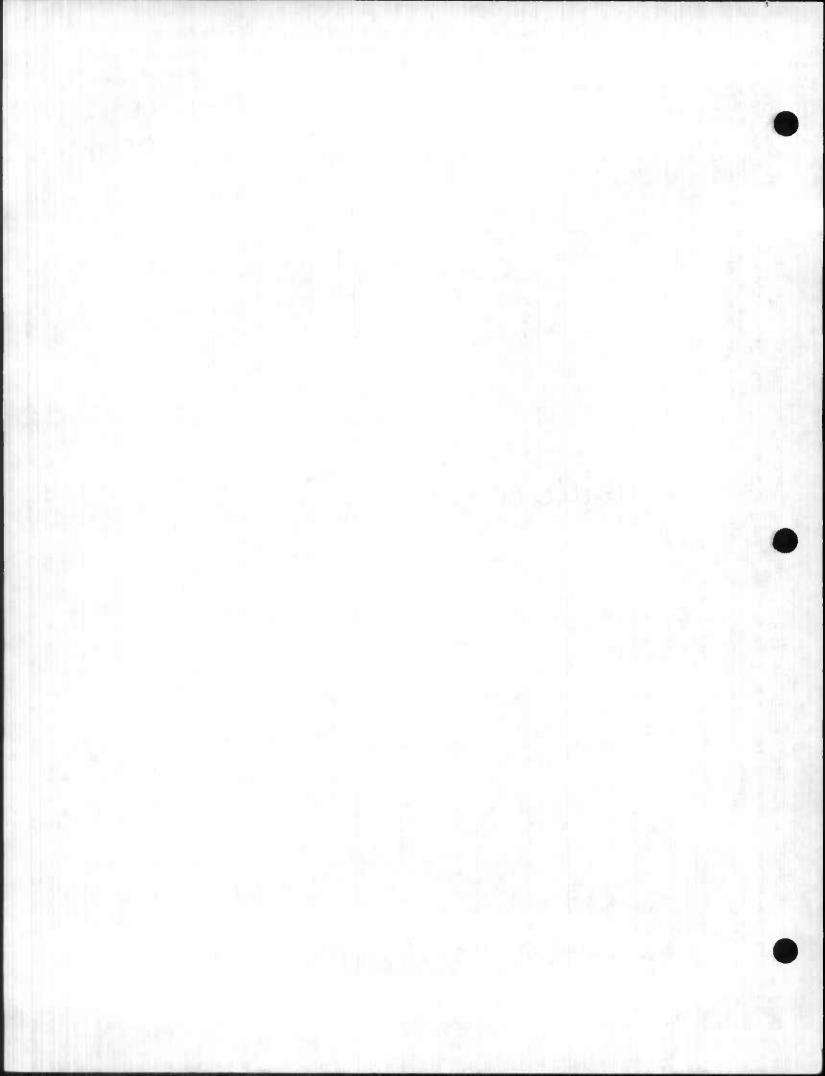


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				Certificate of	Death		eg. No.	
Physician	Decedent's Name (First, Middle, i	Last)				Date of Deat Month	h Day	3. Time of De
/Medical	IRENE			SCROGGIA		HOVEMB	ER 13	2000 7:31A
Examiner	4a Facility Name (If not Institution, s	HOPKING	Hos	pital	4b. City, Town, or Lo Baltir	cation of Death	4c. County	of Death
Funeral Director	5. Sociel Security Number 6. 218-52-4889	. Sex 7. Age	(In yrs. last bir	thday) If Under 1 Yea Months Days		8. Dete of Birth (Month, Day, 07-31-	Year)	Birthpleca (State or For Country) MD
	Usual Residence of Decedent		10.00. 7					
a sho	MD NA		10c. City, Tow					10d. Inside City L
be notified Director	10e. Street and Number		Balti	101. Zip Code		1	0g. Citizen of W	
	1116 Bonapart	ο Ανορμο		21218			mat Country?	
iner must iner must Funeral	11. Marital Stetus	12. Was Decedent E	ver in U.S.			city Yes or No-	USA 14. Race	- American Indian,
xaminer by Fun	XXNever Merried 2 Married 3 Widowed 4 Divorced	Armed Forces?		If Yes, specify Cu 1 ☐ Yes 2 ☐ No	edent of Hispanic Origin? (Specify cuben, Mexican, Puerto Rices) No Specify:			k, White, etc.
ted bet	15. Decedent's	Educetion	16a.	Decedent's Usual Occu	upation		16b. Kind of Bu	siness/Industry
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Con the	12th Grade	4yrs.		Nurse				s Health
B even	17. Father's Name (First, Middle, La				18. Mother's Neme			Θ)
To To	Joseph S.	Scroggin			Pearl		oynes	
T is in	19e. Informant's Name/Relationship Pearl R. Sc	(Type, Print) Croqqins						State, Zip Code) 21:
the Z	20e. Method of Disposition	210991115	, ,	Disposition (Name of	arce Aven			City or Town, State
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1 Burial 2 ☐ Cremation 3		cem efer	y, crematory or other pl				
and and and and and and and and and and	4 Donetion 5 Other (Special Signature of Fuperal Service, Light		vosne	ell Mem. (
Dep	· Oa boull	(1) CIDA	2 3		В			ryland 21:
	23a. Part1. Enter the disease, or co	molications that caused	the death Dou		March FH			h Avenue
ysician	shock, or heert failure. List on	ly one cause on each lin-	θ.	iot dittor the mode or a	ying, soon os condido c	rospiratory arm	531,	Interval Betwee Onset and Dea
Medical	Immediate Cause (Finat	.15.	(= = . () .	LAR FIBR	LIATION	1		TWENTY
aminer	disease or condition resulting in death)	0.		consequence of):	Callette			MINUTE
je je			300 10 (01 40 4 1	3011304401130 317.				1
n and ial-transit Examiner	Sequentially list conditions,	b	Due to (or es e	consequence of):				
burial-tran	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury	•						1
200	that initiated events resulting in death) Last		Due to (or es e o	onsequence of):				
iding physise es the		d						
attending physician for use as the buna clan/Medical E					Philips of			
ed by the deteched	Part II. Other significant conditions	contributing to death bu	t not resulting in	the underlying cause of	given in Part t.			tribute to the cause of d
een signed by hould be detec						1 Y	98 2₫No	3 Probably 4 Uni
tate has been signed by the attending phy page 2 should be deteched for use es the Completed by Physician/Medi						24a. Was a perform	n autopsy ned?	24b. Were autopsy findi aveilable prior to completion of ceus
mp ge 2							1	of death?
certificate har rector, pege	05.141					1 🗆 Ye		1 ☐ Yes 2 Ø No
B B	25. Wes case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:			26. Place of Death		-1	
9 5 0	27. Mannge of Death	28e. Date of Injury	/ 28b. 1	tpatient 3 DOA DOA 28c. Inj	4 Nursing Hol	ne 5 Li Heside 28d. Describe ho		
this raid	Er. Mailing Of Death	(Month, Day	Year) I		fork? ☐ Yes 2 ☐ No			
fler this	1 ☑Naturet 5 ☐ Pending	ion				28f. Location /St	reet and Numb	
fler this uneral di	1 ☑Naturet 5 ☐ Pending	be one Place of Iniv	ry - At home, fe (Specify)	rm, street, factory, office	a	City or Town	n, State)	er or Rural Route Number
fler this uneral di	1 Naturet 2 Accident 3 Suicide 4 Homicide 29a. Certifler (Check only) 1 Pending investigati 6 Could not determine	28e. Place of Injubutding, etc. Physician: To the best of aminer: On the basis of	(Specify) my knowledge	, death occurred at the	time, date end place,	City or Town	use(s) and ma	nner as stated
fler this uneral di	1 Naturet 2 Accident 3 Suicide 4 Homicide 29a. Certifler (Check only one) 1 Naturet 5 Pending investigat 6 Could not determine	28e. Place of Injubuilding, etc. Physician: To the best of	(Specify) my knowledge	, death occurred at the	time, date end place,	City or Town	ause(s) and ma ate and place, a	nner as stated and due to the cause(s)
in 24 hours after death. the Funeral Director: After this pletely filled in by the funeral director. ledical Certification: To	1 Naturet 2 Accident 3 Suicide 4 Homicide 29a. Certifler (Check only one) 29b. Signature and title of cartifler	28e. Place of Injubutding, etc. Physician: To the best of aminer: On the basis of	(Specify) my knowledge examination and ed.	, death occurred at the d/or investigation, in my	time, date end place, a	City or Town	ause(s) and ma ate and place, a	nner as stated

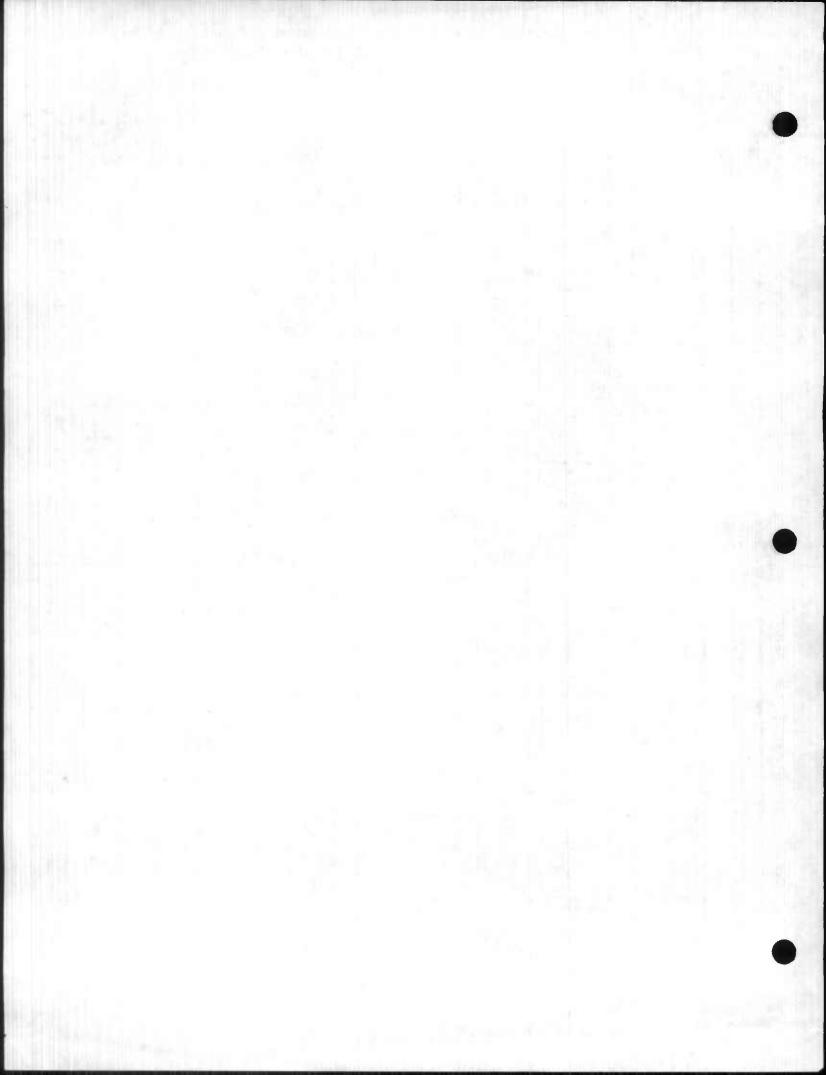
Registrar DHMH 16 Rev 6/95

State



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			Cert	ificate of	Death		Reg. No.			
	1. Decedent's Name (First, Middle, La	ist)	Total The			2. Date of De	afh Day	Vans	3. Time of Death	
Physician /Medical	MICHAEL SUTT					NOVEMBI		2000	8:35 AM	
Examiner	4e Facility Name (II not institution, given	re street end number)			4b. City, Town, o	Location of Death	4c. County	of Death		
	663 CENTER DRIVE				SEVERNA	PARK	ANNE A	RUNDE	I.	
Funeral	5. Social Security Number 6. S	Sex 7. Age (In yr	s. lest birthdey)	If Under 1 Yeer	If Under 24 Hr	s. 8. Date of Birt		9. Birthpla	ace (Stete or Forei	
Director	212-30-3142	10km 20 F 72	Yrs.	Months Days	Hours Mir	Aug 22	y, rear)	Eston	* .	
	Usual Residence of Decedent	1 6				1105 22	, 1720	Docon	124	
Man Hand	10a. State 10b. County	10c. C	City, Town or Loca	ation				10	d. Inside City Limi	
Mary tah	Maryland Anne A	rundel Ser	verna Pa	rk					1 ☐ Yes 2 ☑ N	
vith the Mar or 28a-1 a be noutled	10a. Street and Number	rander be-	velha la	10f. Zip Code			10g. Citizen of	What Count	Vhat Country?	
hours effer death with the Maryland ural; or flems 23a or 28a-f ahow Exercites must be notified at id by Funeral Director	663 Center Drive			2114	. 6	100				
fler death v flore country		AO Was Danadest Francis	11.6			Cassifu Van as Na	U.S.A.	e - America	n Indian	
de de Cu	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U,S. 13. W	Yes, specify Cub	an, Mexicen, Pue	Specify Yes or No arto Rican, etc.)		ck, White, e		
y F	1 Never Married 2 Married	1 XYes 2 No If Yes, Give	10	Yes 201No	Specify:		Specif	y: Wh	ite	
"natural", o		Year or Detes:							The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	
72 Para ste	15. Decedent's E (Specify only highest an		(Give ki	nt's Usual Occup ind of work done	during most of w	orking	16b. Kind of B	usiness/Indu	ustry	
within than the than	Elementary/Secondary (0-12)	College (1-4or 5+)	life. Do	O NOT use retire	d)					
No.	9		ard Work			Bethle		teel		
E SE SE	17. Father's Name (First, Middle, Last)			18. Mother's N	ame (First, Middle,	Maiden Sumer	ne)		
A STA W	Jaan Sutt				Vesik					
	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Street	end Number or I	Rurel Route Numb	er, City or Town	, Stete, Zip (Code)	
0 0 2 4	Raul Altoja/ nepl	hew	1106	Gloria A	Venue	Baltimor	a. Maru	land 2	1227	
of Health Hem 27 other tru	20a. Method of Disposition	20c. Location								
	1 Buriat 2 □ Cremation 3 □	Removel from State		etory or other ple		Date				
permit. Pages Department of Important: If I eny Injury or pnce.	4 Donation 5 Other (Special	T E				11/13/00) Baltir	nore,	Maryland	
Department Department Important: Pny Injury PNCS.	21. Signature of Funeral Service Lice	nsee	22.	Neme end Addre	Funeral	Home, In	3.0			
20539	1							Mary	land 212	
	23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused the de	eth. Do not enter	the mode of dyin	ng, such as cardi	ec or respiratory a	rrest,	1	Approximate Interval Between	
Physician	Shock, of heart failure. List only	one cause on each line.							Onset and Death	
/Medical	Immediata Cause (Final	makad	1. 1	0					1 24	
Examiner 🗀	disease or condition resulting in death)	. Metasta			ancer			f	1 41	
ē		Due to	(or as a consequ	ence-old:				1		
n and tal-transit		b								
and and Xar	Sequentially list conditions, if any, leading to immediate	Due to	(or as a conseque	ence of):						
cien burie	ceuse. Enter Underlying Cause (Disease or Injury	c	2 4 6					i i		
physicien and s the buriel-transit	that initiated events resulting in death) Last	Due to	(or es a conseque	ence of):						
5 00 5										
a death cer the attendir hed for use /sician/A		0.						1		
deam ed for u	Part II. Other significant conditions of	contributing to death but not re	sulting in the unc	derlying cause gi	ven in Part I.	23b. Dld	tobacco use co	ontribute to	the cause of deal	
F 50						152	Yes 2 No	3 Prob	ably 4 Unkno	
5 00										
een sign hould be						24a. Was	an autopsy		ere autopsy tinding	
D a						perio	ormed?	con	nilable prior to	
has the page 2 a								Of 0	death?	
page Com		aby Irre				10	Yes 2 No	1 🗆	Yes 2 No	
certificate rector, pag	25. Was case referred to medicel examiner?	0 - 30				eath (Check only	one)			
2 00 7	1 ☐ Yes 2 🛣 No	Hospital: 1 Inpatient 2	☐ ER/Outpatient	3□ DOA ON	her: 4 Nursing	Home 5 Resi	dence 6 Ot	her (Specify)	
Afrag Ph h. After th funeral	27. Manner of Deeth	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo	ry at	28d. Describe	how injury occu	rred		
Attending ir death. ector: After by the fune ification	1 Natural 5 Pending 2 Accident Investigation		,,		Yes 2□No					
tal or Attending in a ster death. el Director: After to de in by the funera Certification:	3 Suicide 6 Could not be determined	256. Place of Injury - At		et, fectory, office		281. Location (ber or Rurel	Route Number,	
din din	4 E Homicide	building, etc. (Spec	ciny)			City of 10	wn, State)			
	29a, Certifier 153 Certifying Pt	valcian: To the best of my ki	nowledge death	occurred at the fi	me date and nia	ce and due to the	cause(s) and m	anner as st	ated	
n 24 hound he Fund pletely fill edical	29a. Certifier 125 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cell of the cause (s) and manner stated.									
Me de M		and manner stated.		29c. Licens	na aumhar		29d. Date sign	nd (Month I	Day Voorl	
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	JAVIER BOW	ANOSMEADE	am,	OPR	PB915	0.00	11-13.	.00		
HXI	30. Name and address of person who		em 23a) (Type, P							
1/1/	JAVIER BOLANOS	MEADE, MI) 10 M	I GREEN	VE B	PLTIMON	25 m	21	701	
Ctoto	31. Date filed (Manth Day, Year)	32. Registrar's Sign		Acc 11	0 1		11			
State	NUV 1 6 20	(1) Linear	1	poporio	20					



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State of Manyland / Department of Health and Mental Hygiene U 3 6 1 3 5

				Oldic Oi	mar yrana /		ificate of	Death		Reg. No.		0900
Obveision	_	ecedent's Name (Fi	irst, Middle, La	st)					2. Date of De	eath Day	Year	3. Time of Death
Physician /Medical		Hari	ry Lewi	s Shay					Novembe	r 14, 20	000	6:00 a.m.
Examiner	4-0	Facility Neme (If not						4b. City, Town, or	Location of Deat	h 4c. County	of Death	
		Brightwo	ood Nur	sing Hon	le			Luthervi		Balti	more	
Funeral Director	40	oclel Security Numb	5 1	M 2DF	Age (In yrs. last		If Under 1 Year Months Days	Hours Min.				lece (State or Foreign try) nce, Ky.
P 3		al Residence of Dec	b. County		10c. City, To	own or Loca	tion				1	0d. Inside City Limits
or 28a-f show be notified at	5	Md. I	Baltimo	22.	Tarth	ervil	7.0					1 ☐ Yes 2 📜 No
or 28ed a be notified	10e	. Street and Number		16	Jul 61	GIATI	10f. Zip Code		4 8 1	10g. Citizen of W	/hat Coun	try?
		515 Bri	ightfie	ld Road		NE.	21093			U.S.A.		
lar dos llama llama	201	Marital Status 1 □ Never Married 3 ☑ Widowed 4 □		12. Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or Dat	No	11)	as Decedent of I Yes, specify Cub	dispenic Origin? (Sen, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	Black	- Americ k, White,	
		Α	Decedent's Ed			6a. Decede	nt's Usual Occup	pation		16b. Kind of Bu	sinass/Inc	Justry
1 21215-0 od within 72 ho vgiene. wr then 'natur k, the Medical.			nly highest gra	de completed)		(Give kii	nd of work done NOT use retire	during most of wo	rking			in the same
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Da da da da da da da da da da da da da da		Father's Name (Firs				40.3	325			, Maiden Sumam	e)	
yla Nonid Men	5		John	Lewis Sh	ay			Ethel	Prownin	ıg		
Aar 2 sty	19€	. Informant's Name/	Reletionship (Type, Print)	1	9b. Malling	Address (Street	and Number or R	ural Route Numb	per, City or Town,	State, Zip	Code)
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altimore mit. Pages 1- partment of He portant if Ner y Hejery or oth	208	. Method of Disposit 1	remation 3 [0.000.0	itery, creme	tory or other pla	ce)	Date			
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Ba Depa Impo any li	21.	Signeture of Funera	II Service Licer	1500				Funeral (P. A.		
		a. Part / Enter the d	11.7	Junour							lls.	Md. 21117
	23	a. Fam / Enter the di	lure. List only	one cause on ear	ch line.	o not enter	the mode of dyl	ng, such as cardia	c or respiratory a	arrest, O		Interval Between Onset and Deeth
Physician /Medical	Imr	nediete Cause (Fina	nt .	n	EMENT	-10						
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that the ded by detac		Deh	ydru	itur					10	Yea 2□ No	3 9 170	bably 4 Unknown
Il Records, P.O. Box 6 The law requires that the death certificate has been signed by the attending page 2 should be detached for use as Completed by Physician/Me	3	Porch	10-	calmo	mal	met	- ha		24a. Was	s an autopsy ormed?	24b. W	ere autopsy findings allable prior to
s bee	_	, 001				- 7007	701000		pen	Offined I	co	mpletion of cause death?
Vital Relations The law certificate has rector, page 2	5								10	Yes 2 No	10	Yes 2 No
/ital	25.	Was cese referred t	to medicel					26. Place of De	ath (Check only	one)		
Of Vita Physician: this certific ral director.		examiner? 1 Yes 2 Ho		Hospital: 1 In	patient 2 ER/	Outpatient	3□ DOA Ot	her: 49 Nursing I	Home 5□ Res	idence 6 DOth	er (Specif	y)
og Ph og Ph neral	27.	Manner of Death	☐ Panding	28a. Date of (Month,	Injury 281 Day Year)	b. Time of Injury	28c. Inju	ry at ork?	28d. Describe	how injury occurr	ed	
VISION Attending r deeth. ctor: Afte by the fune		2 Accident	Investigation	1				Yes 2□No				
Division of Vital at or Attending Physician: The safer death. No Infector: After this certificate ad in by the funeral director, per Certification: To Be Co		3 ☐ Suicide 6 4 ☐ Homicide	Could not be determined	28e. Place of building	f Injury - At home g, etc. (Specify)	, farm, stree	et, factory, office		28f. Location City or To	(Street and Numb own, Stete)	er or Rure	al Route Number,
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To to to to to to to to to to to to to to		. Signature and title	of certifier			na 1	29c. Licen			29d. Date signed	d (Month,	Day, Year)
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01/	/ -	Name end address	1 HA	fl-m1,	P21 A	J, El	ITAW	of fruit	£ 30f	13all	r. 18	D 2120
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DHMH 16 Rev 6/95				1		and a	18. C. C. De . K.	1.2		** ** ** **		

ORIGINAL.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month 2000 13 Torrence 11 7:05am Genevieve 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Dulaney Towson Nursing Home 5. Social Security Number 6. Sex 7. Ann In urs Leet Baltimore Towson If Under 24 Hrs. 6. Data of Birth Hours Min. 6. Month, Day, Year) If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months 1□M 20 F 98 216-36-3453 Usual Rasidance of Decedent M.D. 10a Stata 10b County 10c. City, Town or Location 10d. Inside City Limits Mas 2 No MD Baltimore NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21217 2229 Madison Ave 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ② No If Yes, Giva Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Nevar Married 2 ☐ Married 1 Yas 2 No Specify: Specify: 3 ☐ Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed 12th grade Seamstress 18. Mother's Nama (First, Middle, Maiden Surname) 17. Father's Nama (First, Middle, Last) Georgia Brotten Oliver Merritt 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Olivia T. Bannister G-Daughter 3036 Tioga Park Way, Baltimore Md 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ♦ Burial 2 Cremation 3 Removal from Stata 4 Donation 5 Othar (Specify) Cathedral Ceme. 11/17/00 Baltimore, Md 21. Signatura of Juneral Service Liger 22. Nama and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215 Do not entar the mode of dying, such as cardiac or respiratory arrest, Approximata Interval Between Onset and Death Immediata Cause (Final disaasa or condition rasulting in death) ents Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4€ Unknown 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 Yes 2 No 25. Was casa rafarred to medical axaminar? 26. Place of Death (Check only one) 1 Yas 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 ☐ Residence 6 ☐ Othar (Specify) 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred Injury at Work?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

natural', or

permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hyglene. Important: if item 27 is marked other than "nat, any injury or other traumatic event, the Medical page.

Director

Funeral

à

Completed

the Maryland

death v

72 hours after

Baltimore, Maryland 21215-0020

68760 Box o 0 Records, Division of Vital Alloc death.

Physician/Medical Examiner à Completed Be To Certification:

after death Director: 10 To the Hospital or within 24 hours at To 1996 Forterral Di

State Registrar

Medical

5 Pending invastigation

6 Could not be

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

29c. License number

1 Yas 2 No

1 decritifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 25a) (Type, Print) X/AOZHOU 300 E NOVTHU Thern

31. Data tiled (Month, Day, Year)

29b. Signatura and this of certifier

1 Natural

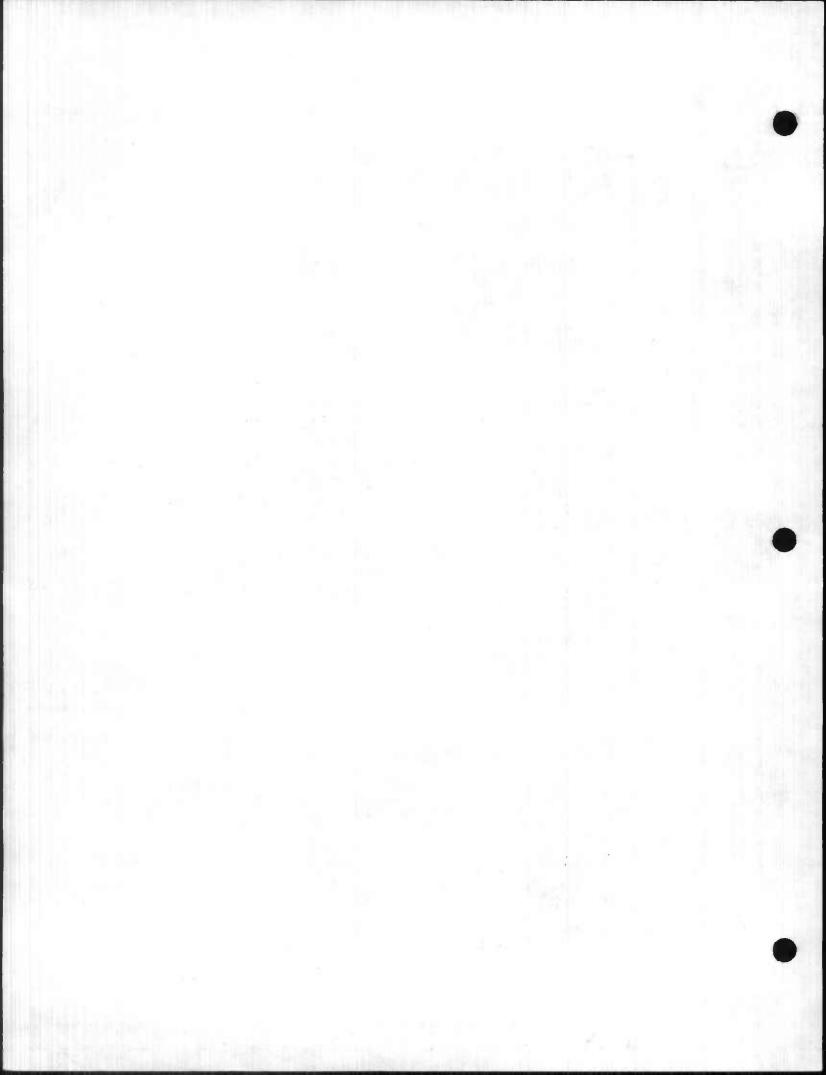
2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

32. Registrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 36437 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** :30 AN 40 NOV. 04 Vesley 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Baltimore Villa St. Michael tf Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) UNK **Funeral** Months Days Hours 1 MM 2□ F 218-18-6028 Yrs. Director 61 Dec 23, 1938 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Med cal Examiner must be notified at 72 hours efter deeth with the Marylet NO Yes 2 □ No Director Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? THomas, Sylvester 21215 4800 Seton Drive USA Funeral unk 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indien. 11. Marital Status Black, White, etc. unk 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry unk unk permit. Peges 1 and 2 should be filed within 7 Department of Health and Mentel Hygiene. Important: If Item 27 Is marked other than "neny injury or other traumatic event, the Med once. College (1-4or 5+) Elementary/Secondary (0-12) unk unk unk 18. Mother'a Neme (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be To 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk 19a. informent's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burlel 2 Cremetion 3 Removel from State 4 Donation 3 Other (Specify) in State Ronald S. Wade, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 1 ans Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner ettending physicien end for use es the burief-transit certificate be exacuted Due to (or es e consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury Division of Vital Records, P.O. Box 68760, Physician/Medical thet initieted events resulting in death) Last signed by the e Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate hes ED No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) 10 1 Inpatient 2 ER/Outpatient 3 DOA After this funerel 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. tnjury at Work? Hospital or Attanding P n 24 hours after death.
 Funeral Director: After the Neturel 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier Cartifying Physician: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) and manner as stated. Medical 2 Medical Examinar: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the Vithin 2 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

2000

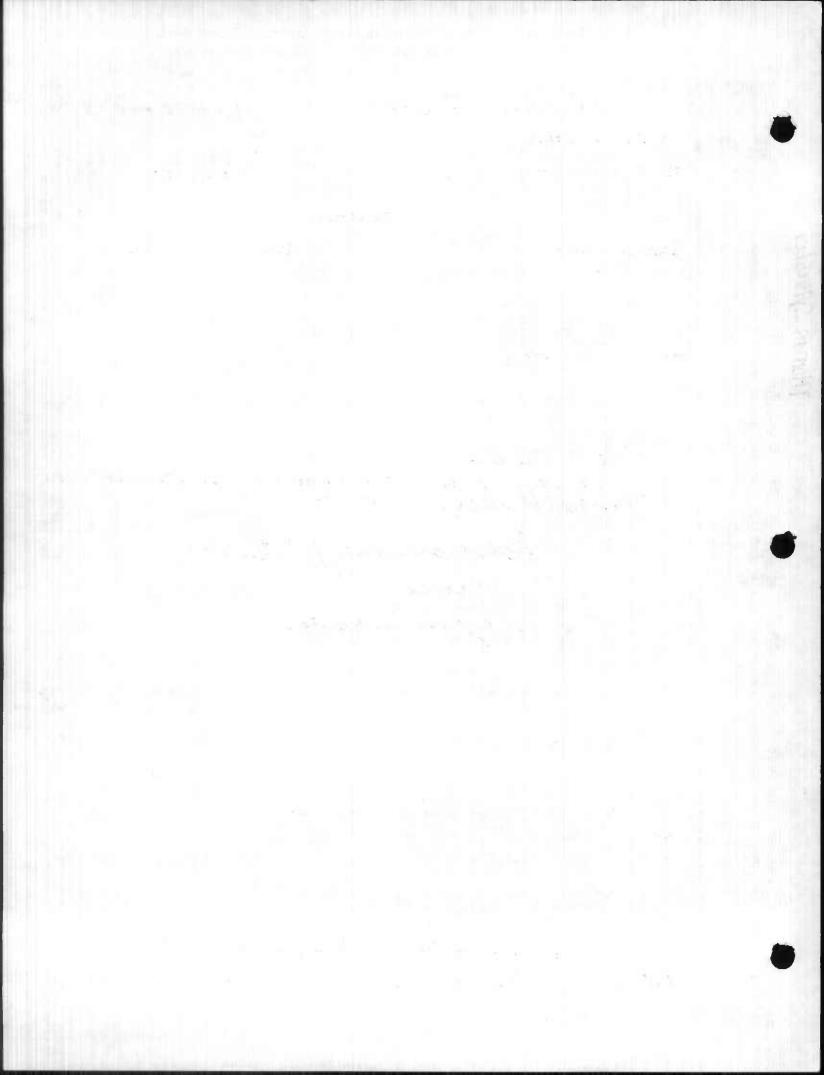
32. Registr#'s Signature

31. Date filed (Month, Dey; Year)

NON

State

Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death Day Month Year 13-00 5:00 a.m leresita Dister lar 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Sisters 16/ake 07 rovidence 1/0 TUnder 24 Hrs. 8. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Data of Birth (Month, Day, Year) 6. Sax Days Months Min. 1 M 2 KF Houra 220-60-8054 Usual Residence of Decedent Lllineis 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No MD IMORE 10a. Sfreet and Number 10f. Zip Code 10g. Citizen of What Country? SA 2/227 - 3899 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yae, specify Cuban, Mexicen, Puerto Rican, etc.) 201 020 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ₹ No If Yes, Give Year or Detes: 14. Race - American Indien, 11. Merifal Sfafua Bleck, White, etc. 1 Never Married 2 Merried 1 Yes 2 No Specify: Blac 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) eacher chee. BS 17. Fether's Name (First, Middle, Last) 18. Mothar's Neme (First, Middle, Maiden Sumeme) Chamas dehn 1 atrick 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) 19e. Informant's Name/Raletlonship (Type, Print) Alexis SP DOI Gun Road 20b. Place of Disposition (Name of camelery, crametory or other place) Sisker M. 20a. Method of Disposition Tisher, OSP MU 21227-3899 Dete 20c. Location - City or Town, Stete 18 Burial 2 Cramation 3 Removal from Stete Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) oudon emetery 21. Signeture of Funerel Service Licenses 22. Name end Address of Facility March Funeral Lad Warnes Avenue 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, MO21215 Approximate Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting In deeth) IWK Due to (or es e consequence of): en M Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated evants resulting in death) Lest Due to (or es a consequance of): Due to (or es e consequence of) Pert II. Other aignificant conditions contributing to death but not rasulting In the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of causa of deeth? 24a. Wes an autopsy performed' 1 Yes 7 20 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only ona) Hospitel: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred Injun

requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Box 68760, Division of Vital Records, page 2 this certificate has P Physician: is or Attending Planter death.

I Director: After the in by the funera To the Hospital or within 24 hours after To the Funeral Director Completely filled in b

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or lterns 23e or 28e-f show the Medical Examiner must be notified at

filed within

Mental le marked

Pages 1 and 2 s ment of Health an ant: If Nem 27 is

permit. Pages Department of Important: If a any injury or one

Physician

/Medical

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Baltimore,

Director

Funeral

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Completed

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Physician/Medical Examiner p Completed 8 Certification: To 1 Natural 2 Accident 3 Suicide 4 Homicide edicai 29a Certifier

25. Wes cese referred to medicei examiner? 1 Yes 2 No 27. Manner of Death

5 Panding

investigation 6 ☐ Could not be detarmined

28e. Plece of Injury - At homa, farm, street, fectory, office building, atc. (Specify)

1 Yas

2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

1 Certifying Physician: To tha best of my knowledga, death occurred et the time, dete end place, end dua to tha cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, daath occurred at tha time, dete end place, and dua to the cause(s) end menner stated.

29b. Signeture end fitle of continuo

29c. Licansa number

29d. Deta signed (Month, Day, Year)

30. Nama end address of person who complated ceuse of death (Item 23e) (Type, Print) 18KARAN AMBANDAY

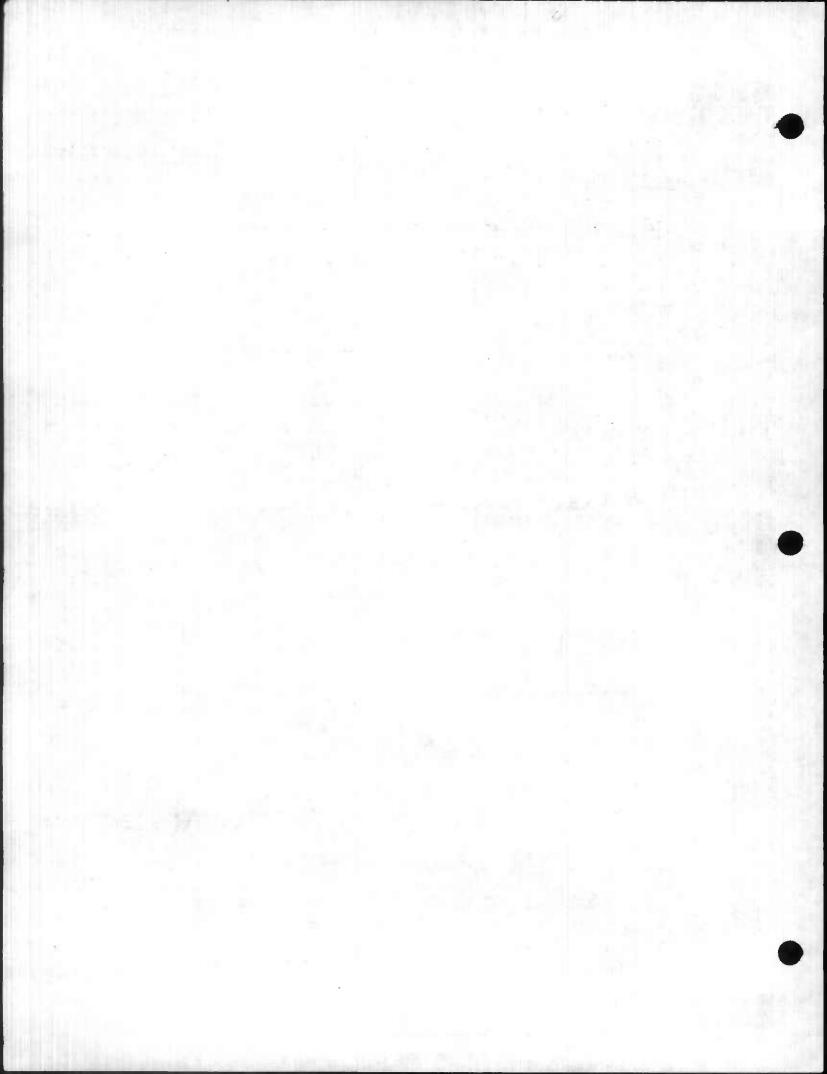
31. Dete filed (Month, Dey, Year) 6 2000 NOV 1

32. Registrer's Signeture

Dorker.

State

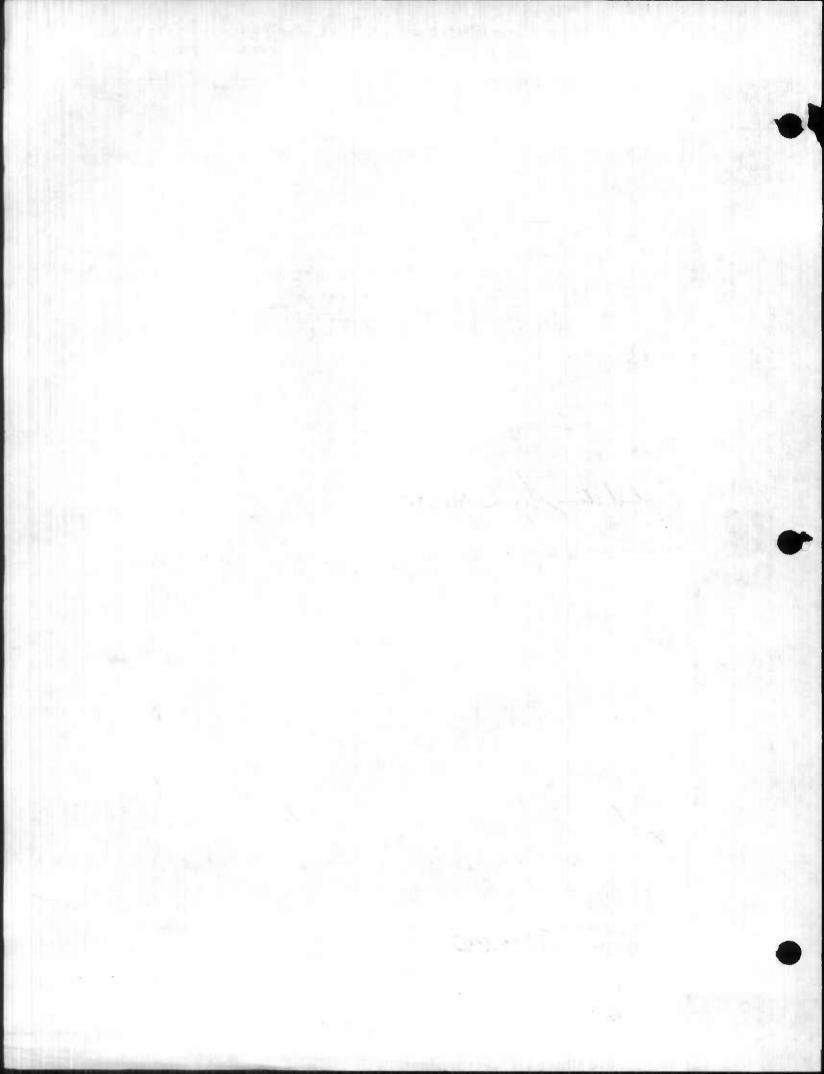
Registrar



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/Medical Examiner	4.	a Facility Neme ((If not Institution, g	give street and n	umber)	11-1-		4	b. City, Town, o	r Location of Dea		County		
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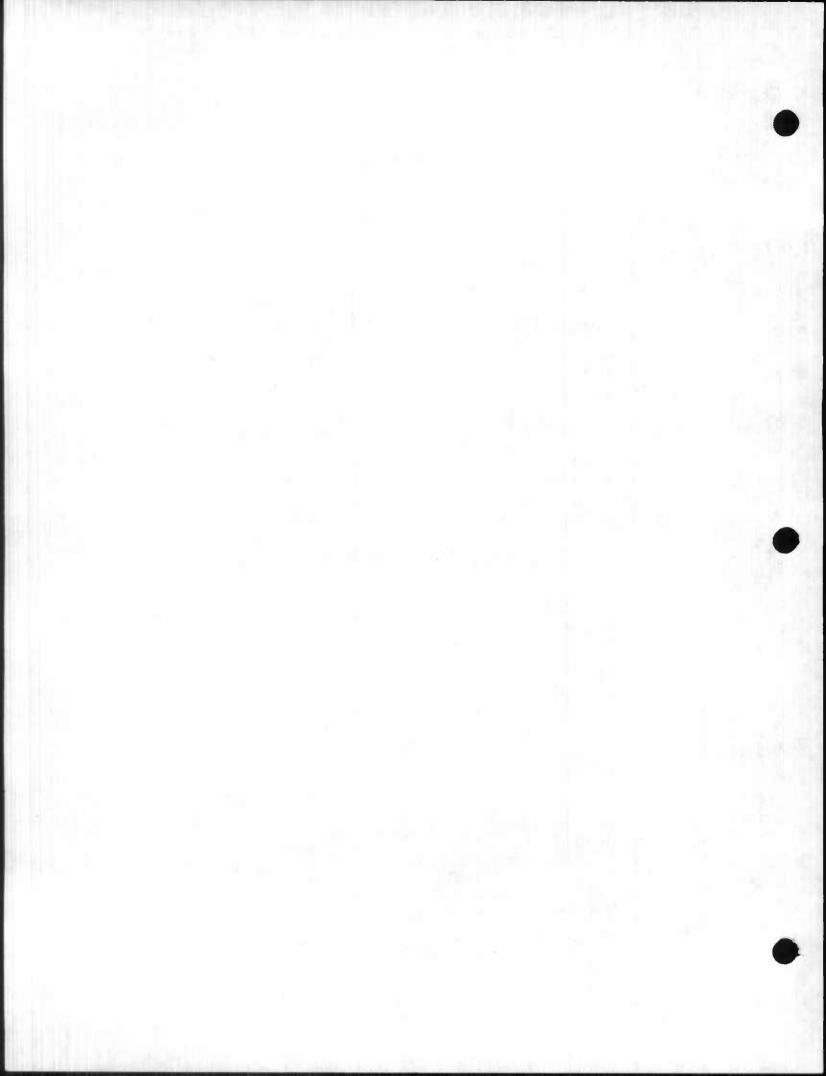
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** KATHERINE NOV 14 1121 AM 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner APIAKE (PEDICAL) UPPER day) If Under 1 HARFORC 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1□ M 200 F Months Days Hours Min. 92 BUSTANIE Usual Residence of Decedent Director JULY 14 1908 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 23 No Directo HARFORE MARYARO JARRITTIVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? en "natural", or itema 23a or Medical Exeminer must be 1513 BALOW V.S.A KOAC 1/7 21087 Funeral 12. Was Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 ☐ Yes 25 No If Yes, Give Year or Detes: TSO Never Merried 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: specify: WHITS p 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry CHILDEVALORISM FELLOWSHIP OF ELEARFIND LOUNT Elementery/Secondery (0-12) College (1-4or 5+) IDYRS DIRECTOR RIFICATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) h and Mental I ahould be JARY JANE Yound CLARK 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 21084 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 a ment of Health an ant: If Nam 27 is 1 1513 BOLDWIN MILL ROAD JARRETTEVILLE WITHERIT MARGLARO HAROLO Baltimore. 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date UOV- 18 Burial 2 Cremation 3 Removal from State 8 4 Donation 5 ☐ Other (Specify) 5/2/2 3000 JORDAN MUSAFASUE 21. Signature of Fugeral Service Doens 22. Name and Address of Facility EVAN FUNKAL CHAPIL-BIL QIR. P.A. 3 NEW PORT DRIVE FOREST HILL 23a. Part1. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Hemorrage Examiner Due to (or as a consequence of): Physician/Medical Examiner Westralous Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events certificate be axecuted attending physician and for use as the burial-tran Due to (or es a consequence of) of Vital Records, P.O. Box 68760 that initiated events resulting in death) Last Due to (or as a consequenca of) signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 No 3 | Probably 4 | Unknown py 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy Completed peeu drector, page 2 s 1 ☐ Yes 2 D10 1 Yes 22 No 8 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 큠 27. Menner of Death 28c. tnjury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of tnjury - At home, farm, street, factory, offica building, etc. (Specify) 4 ☐ Homicide b 1 ☐ Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. edical 29a. Certifier To the Hos (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NOVEMBU Ms 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) MD 21014 Steinmel Bul AIT. Scatt / A 516 Upper (hisapieke

Registrar

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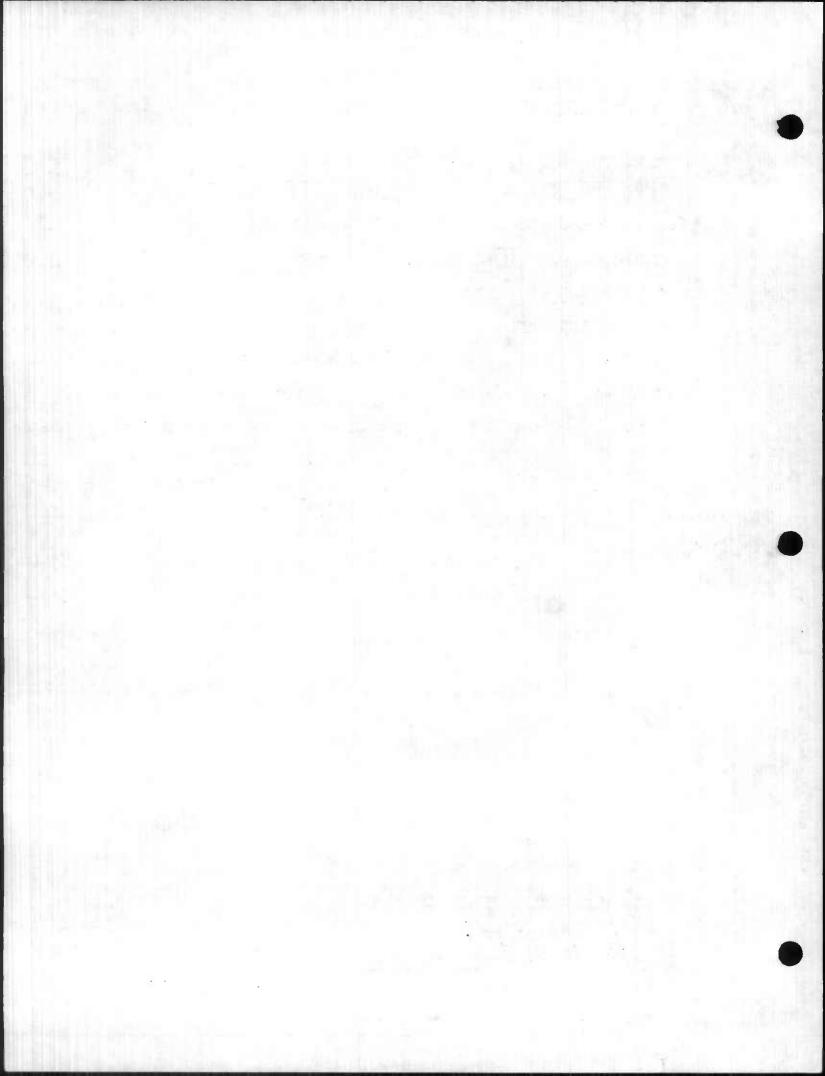
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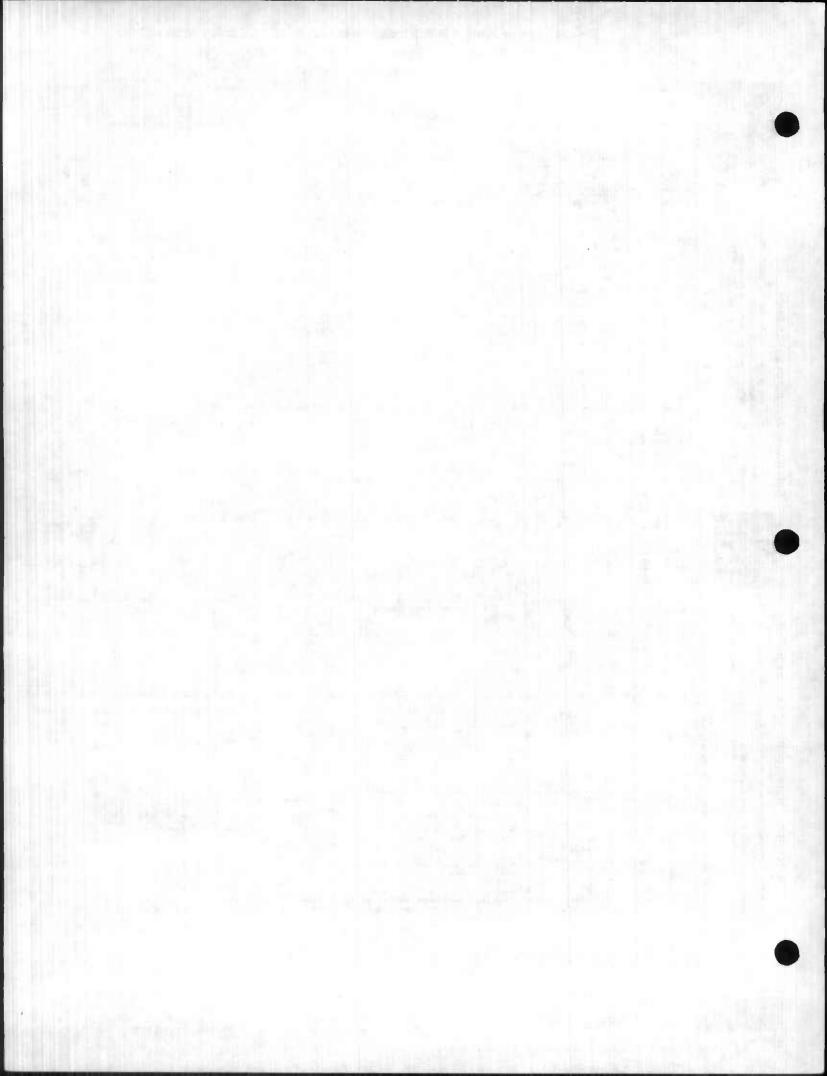


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State of Maryland / Department of Health and Mental Hygiene

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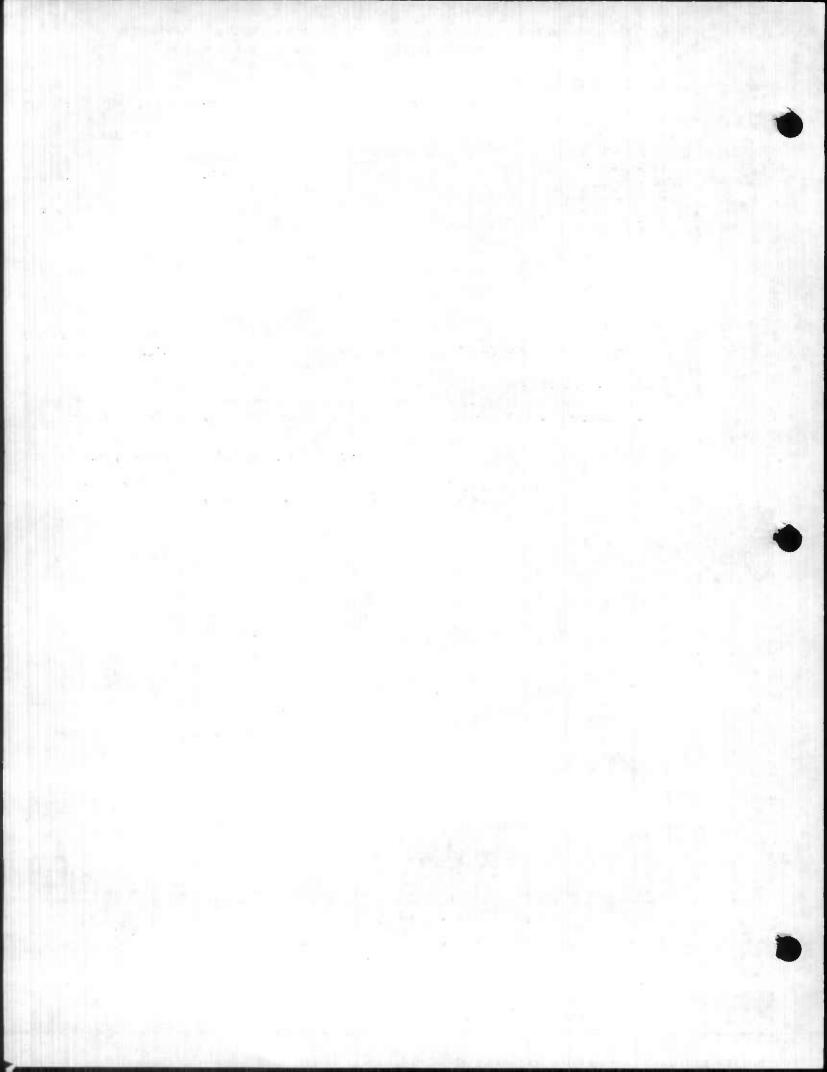


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	Certificate of Death	Reg. No.
Physician	Decedent's Neme (First, Middle, Last) William Michael Williamson	2. Date of Death Month Dey Year Notycombo v 10 2000 9-10 DM
/Medical		November 10, 2000 8:10 PM or Location of Death 4c. County of Death
Examiner	611 Tee Jay Lane Dunda	
Funeral . Director	212-60-1680 X M 2UF 49 Yrs.	Hrs. 8. Dete of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Feb. 23,1951 West Virginia
2	Usual Residence of Deceden1 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Manyi of sho fied at	Maryland Baltimore Dundalk	1 ☐ Yes 2OXNo
or 28a-f s or 28a-f s be notified	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
	611 Tee Jay Lane 21222	United States
Maryland 21215-0036 dig should be filed within 72 hours after death vin and Mental Hyperes. 7 Is marked other than "natural", or flams 23d traumatic event, the Medical Examinar mast To Be Completed by Funeral	11. Merital Stetus 1 □ Never Merried 2 Merried 3 □ Widowed 4 □ Divorced 12. Wes Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 No If Yes, Specify Cuban, Mexicen, Pi If Yes, Sive Year or Dates: 13. Wes Decedent of Hispanic Origin? 14. Wes Decedent of Hispanic Origin? 15. Wes Decedent Ever in U,S. Armed Forces? 16. Yes, Sive Year or Dates:	7 (Specify Yes or No- uerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. Specify: White
5-0 72 ho matur disali	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use reliared) 17	working 16b. Kind of Business/Industry
21215-0 ed within 72 ho spiere. ee than 'natur r, the Medical.	Elamantary/Secondary (0-12) College (1-4or 5+)	Madde Water Treatment
nd 2		Institution Name (First, Middle, Maider Surname)
Vlar Widows Wents Wents of His en	Carl E. Williamson	ois Jean Knotts
Aary 2 sho		r Rural Routa Number, City or Town, State, Zip Code)
	Mrs. Margaret E. Williamson 611 Tee Jay Lane 20a. Mathod of Disposition (Name of	Dundalk, Maryland 21222 Date 20c. Location - City or Town, State
altimore, mit. Pages 1 at partment of Hea portant; Il lisen; y injury or other as.	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stete Donetion 5 ☐ Other (Specify) Cemetery, cremetory or other plece) Hilltop Service Corp.	11/14/2000 Towson, Maryland
Bal permit Depart Import) (and 1922 Wise Ave.	l Home of Dundalk, Inc. Dundalk, Maryland 21222
Physician /Medical Examiner	Immediate Cause (Final disease or complications that caused the death. Do not enter the mode of dying, such as can shock, or heart feilure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Metas Lafur Jung Concerning Conc	Onset end Deeth
68760, ificate be executed physician and as the burist-transit edical Examiner	Sequentielly list conditions, if any, leading to immediata cause. Entar Underlying Cause, Disease or injury thet initiated events. b. Due to (or as e consequence of):	
	resulting in death) Last d.	
P.O. Box nat the death cent d by the attending elached for use. Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did lobacco uss contributs to the cause of death?
S, P. es that it igned by be detach		1 Yss 2 No 3 Frobably 4 Unknown
cord v requir been s should		24a. Was en eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
The lay ate has page 2		1 Yes 2 No 1 Yes 2 No
Vital Incentificate rector, pag	ayaminar?	Deeth (Check only ona)
To To	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursin	ng Home 5 ☐ Rasidance 6 ☐ Other (Specify) 28d. Dascribe how injury occurred
On ding F	27. Manner of Death 28a. Date of Injury 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 2b	280. Dascribe now injury occurred
- Page 1	3 Sulcide 6 Could not be determined 28e. Placa of Injury - At home, tarm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, Steta)
he Hospital in 24 hours a he Fundral pletery filled edical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledga, death occurred at the tima, date end p (Check only one) 1 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death of and menner stated.	
Me di più	29b. Signeture/end title of certifier 29c. License number	29d. Pate signed (Month, Day, Year)
MO	Jony Waterbury. h.D. Do 9559	11/13/00
UU	30. Name and addrass of person who complated cause of daeth (Itam 23a) (Type, Print) LARRY WATERBURY, AD, JHBAC, 4940 EASTERN &	UE, BALT., MED. 21224
State Registrar	31. Data filed (Month, Dey, Year) NOV 1 6 2000 Sequence A	

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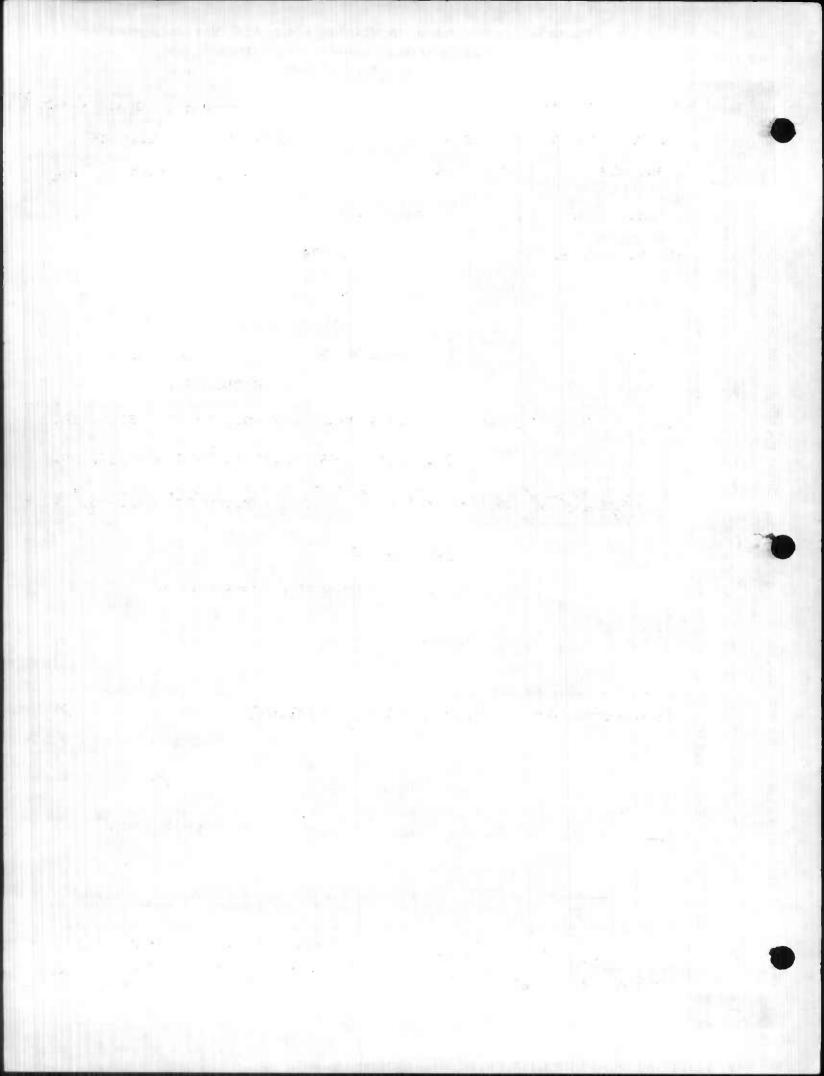


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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daeth Month Z.25 PM **Physician** Bridget F. Weglicki November 11, 2000 /Medical 4b. City, Town, or Location of Deeth 4e Fecility Name (If not institution, give street end number) 4c. County of Death Examiner GENESIS ELDER CARE BRIGHTWOOD LUTHERVILLE BALTIMORE 7. Aga (In yrs. last birthday) If Undar 1 Year 5. Social Security Number 8. Data of Birth (Month, Day, Year) Birthplace (Steta or Foreign Country) **Funeral** 1 M 2 F Months Days Hours 85 Yrs. 219-18-1476 **Director** 27, 1915 MD. Usuel Rasidanca of Dacedant 10e State 10b. County 10c. City. Town or Location 10d. Insida City Limits r 28a-f show the Marylar N/A MD. BALTIMORE 1 X Yes 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? permit. Pages 1 end 2 should be filed within 72 hours after death with Department of Health end Mentel Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or any Injury or other traumatic event, the Modical Examinas must be re-21224 301 S. DREW STREET USA Funeral 12. Wes Decedent Ever In U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yas, Give ^X Yaar or Datas: Was Dacadant of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14 Bace - American Indian Black, Whita, atc. 1 □ Naver Merried 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedant's Education (Spacify only highast grada complated) Elemantery/Secondery (0-12) Collaga (1-4or 5+) HOMEMAKER 7TH OWN_HOME 18. Mothar's Nama (First, Middla, Maidan Sumame) 17. Father's Nema (First, Middla, Last) HELEN OLSOUSKI JOSEPH VRABLIC 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Coda) 21117 19a. Informant's Name/Raiationship (Type, Print) 10605 BROOKLAWN RD., OWINGS MILLS, MD. TIMOTHY WEGLICKI/SON 20b. Piace of Disposition (Nama of cematary, cremetory or other place) 20c. Location - City or Town, Stete 20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) ST. STANISLAUS CEM. 11/14/00 BALTIMORE, MD. 21. Signature of Funarai Sarvica Licansaa 22. Name end Addrass of Facility CHARLES S. ZEILER & SON, INC. noke 23a, Part1. En a fila disaasa, or complications that causad tha death. Do not antar tha mode of dying, such es cardiac or respiratory arrest, shock, or local feilure. List only one-ceuse on each line. MD. 21224 Approximete Intarval Batween Onsat and Death Physician Immediata Causa (Final disaasa or condition rasulting In daath) /Medical SEPSIS Examiner Due to (or as a consequance of): Examiner TRACT INFECTION DRINANY siclan and burial-trensit certificate be executed Sequantially list conditions, it any, laading to Immadiate cause. Enter Underlying Causa (Disaasa or injury that initiated avents rasulting In daath) Last Dua to (or as a consequence of): physician s the burial Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or es e consequence of): 98 nse signed by the a Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably Minknown 1 Yes 2 No À 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed complation of causa of death? page 2 1 ☐ Yas 2 ☐ No 1 Yas certificate Attending Physician: director. 25. Was casa rafarred to medical axaminar? Be 26. Placa of Death (Check only ona) Other: Nursing Homa 5 Rasidance 8 Other (Specify) 20 1 Yas 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Data of injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? Natural 5 Panding 1 ☐ Yas 2 ☐ No 24 hours after deeth. invastigation 2 Accidant 6 Could not be datarminad 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicida 28a. Place of Injury - At home, farm, street, fectory, office building, atc. (Spacify) filled in by 4 Homicida 6 29a. Cartifiar 🚝 Certifying Physician: To tha best of my knowledge, daath occurred at the time, data and place, and dua to tha cause(s) and mannar as stated Medical 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, daath occurred at the time, deta end place, and due to the causa(s) and manner stated. (Check only one) To the 29b. Signatura end titla of certifia 29c. Licansa number 29d. Data signed (Month, Dey, Year) 52360 wo RUBIR SAMONI person who completed causa of deeth (Item 23a) (Type, Print) GITTEENE PIKESVILLE 1838 1125 300 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State Registrar

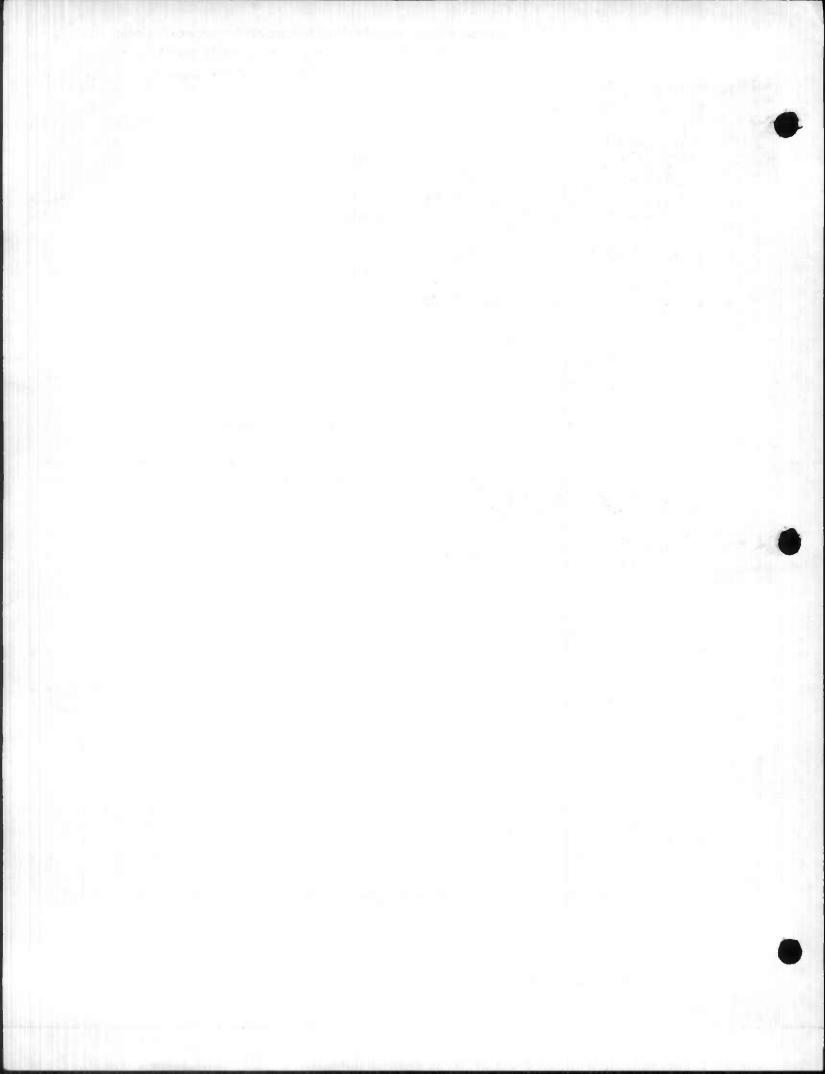
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State of Maryland / Department of Health and Mental Hygiene

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ınerai		5. Social Security Number 6. S		ga (In yrs. lest bii		dar 1 Yaar	If Under 24 Hrs				
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nou-	Se l	10e. Street and Number			10f.	Zip Coda			l0g. Citizen of \	What Country's	7
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	To Be	James McDonoug					Flore	nce			
1	-	19a. Informant's Name/Ralationship (Type, Print)	196	. Mailing Addr	ass (Street	and Number or Ri		r, City or Town,	Stata, Zip Co	de)
		Mark Anders	So	n 18	322 Ma	nsfie	ld Road	Keedvsvi	lle Ma	rvland	21.756
		20a. Mathod of Disposition		20b. Place 0	Disposition (Nama of	ce)	Deta	20c. Location -	City or Town,	State
once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the contro			Hill (1/1/00	Hagerst	own, M	Maryland
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1000	Certification:	3 Suicide 6 Could not b 4 Homicida	28a. Place of it	jury - At homa, fa tc. <i>(Specify)</i>	rm, straat, fac	tory, offica		28f. Location (S City or Tow	traet end Numl n, Stata)	per or Rural R	oute Number,
	edical	29a. Certifiar (Check only one) 1 ☐ Cartifying Ph	rad at tha tir tion, In my c	ma, data and place opinion, daath occu	a, and dua to tha d urred at tha tima, d	ausa(s) and ma lata and place,	annar as state and dua to the	d. a causa(s)			
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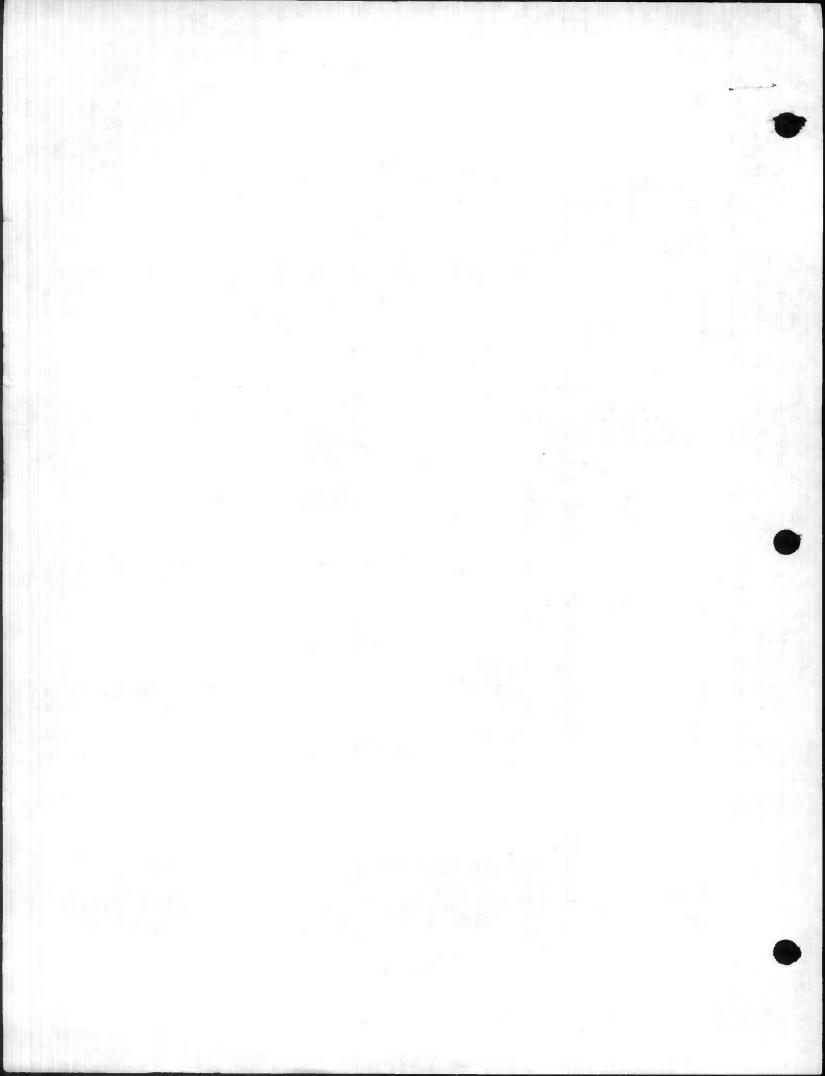


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State of Maryland / Department of Health and Mental Hygiene

Physician	. & 8. Per Fam. PGC 1. Decedent's Name (First, Middle, L Carlos Alexan	est)		ertificate		2. Date of I Month	Day	Year	3. Time of Death
/Medical	4a Facility Name (If not institution, g					Octobe n, or Location of De		of Deeth	10:37 P.M
Examiner	Prince George		l Center			verly		e Geor	rge's
Funeral Director	219-82-1072		(In yrs. last birthda 7 38 Yrs			Hrs. 8. Date of 8 (Month, 7/31/	Birth Day, Year)		e (State or Foreign
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at be notified at Director	10e. Street and Number 7005 Shepherd St	creet		10f. Zip C	207	84	10g. Citizen of V	_	?
by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2(7) If Yes, Give Year or Dates:	o U,S. 1	3. Was Deceder If Yes, specify 1 Yes 25		n? (Specity Yes or I Puerto Rican, etc.)	No- 14. Rac Biad Specify	a - American k, White, etc	
Completed	15. Decedent's I (Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5	(G	cedent's Usual (ive kind of work e. DO NOT use an Offic	done during most of retired)	of working	16b. Kind of Bu	10.6	
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To Be	Henry Alexa			100	M	lary Johns	son		
er trauma	19a. Informent's Name/Relationship Jennifer Alexande		19b. M			or Rural Route Num t., Landov			
ury or oth	20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Special Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of			sposition (Name crematory or oth Mem. Po	r plece)	Date 0/31/00	20c. Location -		
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as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as a con	sequence of):					
attending of a for use as ician/Me		d							
Phys	Part fl. Other significant conditions	contributing to death bu	t not resulting in th	e underlying cau	se given in Part I.		id tobacco use co □ Yes 22 No		he cause of death? bly 4 Unknown
page 2 should be d							as an autopsy enformed?	availa	autopsy findings able prior to detion of cause ath?
Com						U	Yes 2□No	1di	res 2□ No
Be	25. Was case referred to medical examiner?				T	of Death (Check on	ly one)		
funeral funeral	1 X Yes 2 No 27. Menner of Death 1 Neturel 5 Pending 2 Accident investigati	Hospitel: 1 Inpatie 28e. Dete of Injur (Month, Day			Other: 4 Nurs Injury at Work? 1 Yes 2 N		esidenca 6 Oth be how injury occur		
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To the Funeral Director: completely filled in by the Medical Certifical	29a. Cartifier 1 Certifying F (Check only one) 1 Medical Exu	hysician: To the best of miner: On the basis of and manner sta	examinetion and/o	eath occurred at r investigation, li	the time, dete and my opinion, deeth	plece, and due to to a occurred at the time	ne, dete end place,	and due to th	ne ceuse(s)
7)	29b. Signature and title of certifier 30. Name and address of person who	1 No	cold J	n.P.	icense number	C.M.E.	29d. Date signe October		
State Registrar		2adentz 3e. Registra			Street,	Baltimo	re, Maryl	and 21	201

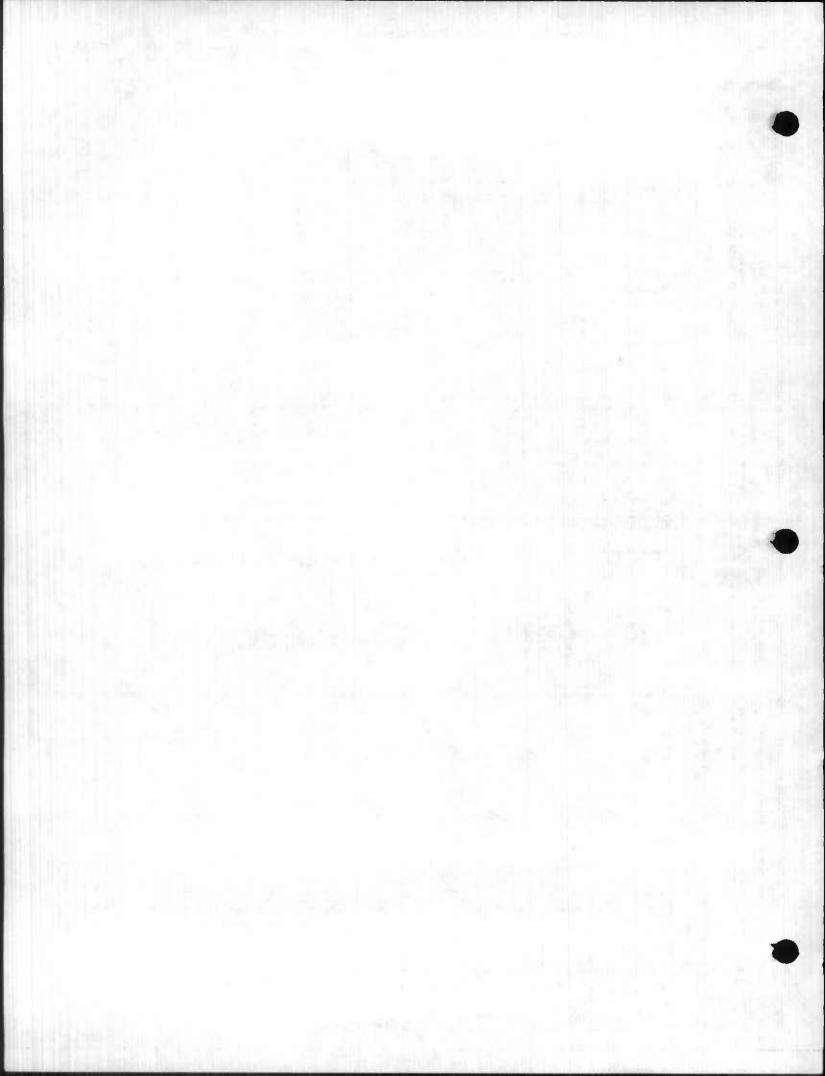
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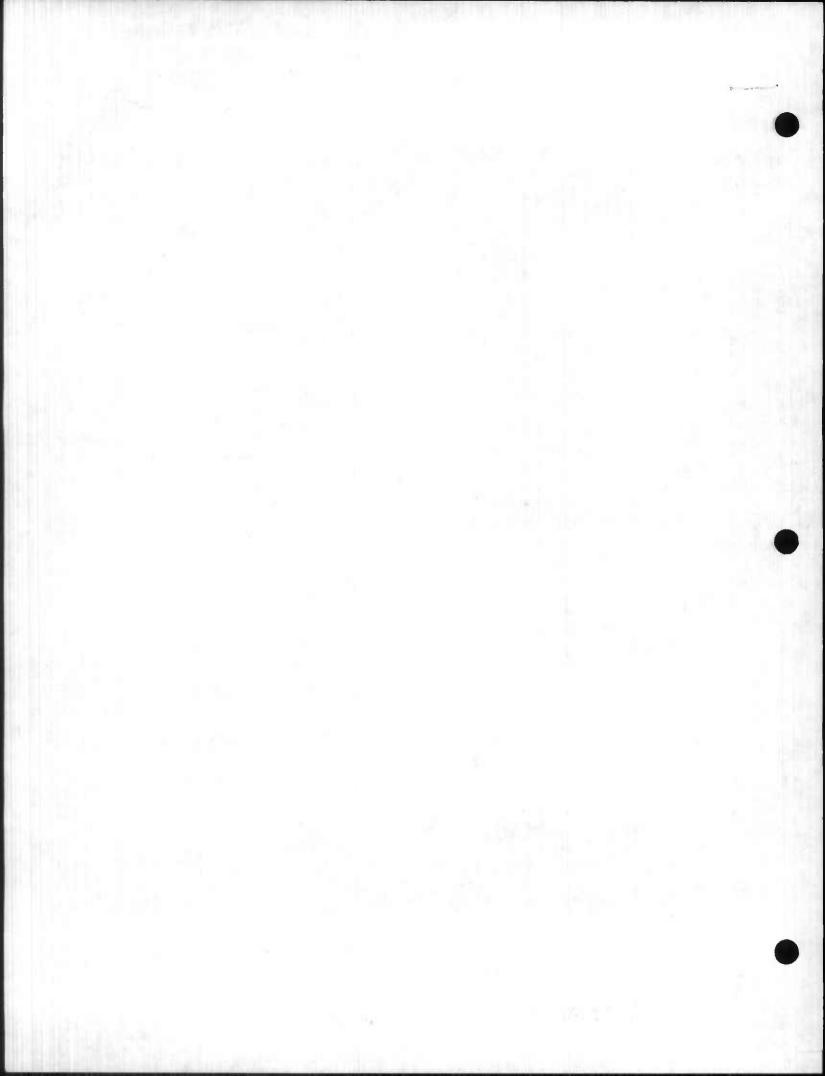
	Certificate of Death		Reg. No.							
	1. Decedent's Name (First, Middle, Last)	2. Date of D		3. Tima of Death						
hysician	Margie Lee Anderson	Month Oct.2	7,2000	10:00p.m						
Medical xaminer		, or Location of Des								
diffifici	Price George Hospital Cheveri	lv	Prince	Georges						
	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	gh.								
	228-30-2658 1 M 22 F 82 Yrs. Months Days Hours	Min. 8. Date of B	11,1918	9. Birthplace (State or Foreign Country) South Carolina						
	Usual Residence of Decedent	Dept.	11,1010	Soudi Carollia						
	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits						
5	Mayandhia			1 Yes 2 No						
	Va. Alexandria		40= China -4144	hat County 2						
Funeral Director	10a. Streef and Number 10f. Zip Code		10g. Citizen of W	nat Country?						
Las	525 N.Patrick Street 22314		U.S.A.							
ĺ	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Dacedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)	lo- 14. Race Black	- American Indian, , Whita, etc.						
	1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No I□ Yes 2 ☒ No Specify:									
ı	3 N Widowed 4 □ Divorced Year or Dates:		ороспу.	Black						
	15. Decedent's Educetion 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Giva kind of work done during most or	f working	16b. Kind of Bus	siness/Industry						
	Elamentary/Secondary (0-12) College (1-4or 5+)	WORKING								
)	10 Domestic		Private							
	17. Father's Name (First, Middle, Last) 18. Mother's	Name (First, Middl	la, Maiden Sumame)						
0 00	Unknown Mat	ttie Canno	on							
	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of	or Burel Boude Num	her City or Town	State Zin Code)						
	A.Jean Pitts (Grandauchter			, and a doco,						
	525 N. Patrick St.	Alexand	ria.Va.	City or Town, State						
	20a. Mathod of Disposition 20b. Place of Disposition (Nama of cemetary, crematory or other place)	Date	200. Location - V	Dity of Town, State						
	4 Donation 5 Other (Specify) Mt.Comfort Cemetery	11-3-00	Alexand	ria Va						
	21. Signature of Fungral Service Licensee 22. Name and Address of Facility		neral Hom							
	Mullip Bell 311 N. Patrick St									
-	23a. Part1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as ce			Approximate						
	shock, or heart failure. List only one cause on each line.			Onset and Death						
	Immediate Course /Final	2:								
	Immediate Cause (Final disease or condition Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Vascular Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere bro Cere	DISCAS	50							
_	resulting In death) Due to (or as a consequence of):									
Examiner										
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	if any, teading to immediate ceuse. Enter Underlying									
-	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of):		_							
edical	resulting in death) Last									
2	d									
rilysician		1								
A	Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I.			tribute to the caues of death						
Ē		10	Yes 2 16	3 Probably 4 Unknow						
þ										
9		24a. Wa	as an autopsy rformed?	24b. Wara autopsy findings available prior to						
Completed				completion of cause of death?						
;		10	Yes 2 No	1 ☐ Yes 2 ☐ No						
9	25. Was case referred to medicel 26. Place of	f Death (Check only	v one)							
00	examiner? Hospital: Other:			(A) = V A						
10 10	Tomparient 20 200 Tomparient 30 200 Tomparient		sidence 8 Other							
Certification:	1 Deatural 5 Pending (Month, Dey Year) Injury Work?		o now injury occurs							
5	2 Accident Investigation 3 Suicide 6 Could not be									
	3 ☐ Suicide 6 ☐ Could not be datarmined 28e. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify)	28f. Location City or 7	n (Street and Numbi Town, State)	er or Rural Route Number,						
,										
2	29a. Certifier 12 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and									
edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daeth and mannar statad.	occurred at the time	e, data and place, a	and dua to the cause(s)						
Σ	29b. Signature and title of certifier 29c. License number		29d. Date signed	(Month, Day, Year)						
	* Heory c. 45 ya. Jun 03955		(0 - 2	20-12						
	30. Name and eddress of person who completed ceuse of death (Item 23a) (Type, Print) George C. Hallar J. m.n. 4850 Furbes Blvd. Lanhum, Md. 20706									
	George C. Hawar J. m.n. 4850 Forbes &	seva. Cap	inum, m	4. 20100						
te	31. Date filed (Month, Day, Year) 32. Registrar's Signature									
ar	NOV 0 1 2000 Berowa &									



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Amend# 18.	20b.Per FH PGC 11-8-200	0:	ficate of Death	R	eg. No.	36448
Physician	Decedent's Nama (First, Middle, Last)			2. Date of Dea Month 10	31 2000	3. Time of Death 9:07 AM
/Medica	Ernestina Atta-Safoh 4a Facility Name (If not institution, give street and nu	(mher)	4b. City, Town, or		4c. County of Deat	
Examine	Doctor's Hospital		Lanham		Prince Ge	
Funeral Director	5. Social Security Number 6. Sax 1 M 2 F		f Undar 1 Yaar If Under 24 Hrs. Inonths Days Hours Min.		9. Birt	hplece (State or Foreign untry Ghana namkese
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or 25a-f s	MD Prince George's	Riverdale				1 A Yas 2 No
E 877	10e. Street and Number 6603 Greenland St.		10f. Zip Code 20737	1	U.S.A.	untry?
1020 Juna after death 16°, or items 23 Examiner mast	Armed F	2 XNo	s Decedent of Hispanic Origin? (Ses, specify Cuban, Mexican, Puan Yes 2 No Specify:	Specify Yaa or No- to Rican, etc.)	14. Raca - Ame Black, White Specify: B18	a, atc.
Maryland 21215-0020 d'2 should be filed within 72 hours at mand Memila hygiene. T'is merked other than "natural", or traumatic event, the Medical Exami	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (16a. Deceden (Give kin life. DO Bakery	t's Usual Occupation d of work done during most of wo NOT use retired)	rking	16b. Kind of Business/ Private	Industry
Ind 2	17. Father's Name (First, Middle, Last)	Zanczy		me (First, Middle,	Maiden Sumame)	
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Man d 2 sh m and 7 fs re traum	19a. Informant's Name/Relationship (Type, Print) Alex Atta-Safoh		Address (Street and Number or Rivernal Address)			(ip Code)
re, I Heart Hem 27 other to	20a. Method of Disposition	20b. Placa of Dispositi		Date	20c. Location - City or	Town, Stata
Page nent of mrt: If I	1 Burial Cramation 3 Removal from 4 Donalion 5 Other (Specify) Enton			hec 3/88	Silver Spi	cing, MD
Baltimore, permit. Pages 1 at Department of Hea Important: If them; any injury or other pates.	21. Signature of Funeral Servica Licenses	22. N	ame and Address of Facility J		ins Funeral	
	23a. Party. Enter the disease, or complications that stuck, or heart failure. List only one cause on	caused the death. Do not anter t	he mode of dying, such as cardia	c or respiratory are	rest,	Approximate Interval Between
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	gnant Cancer of		2		Onset and Death
60, be executed ician and burial-transit	Sequentially list conditions, if sny, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Static Lung Dis	ease			
ficate ficate phys	Cause (Disease or Injury that initiated events resulting in deeth) Last	Dua to (or as a consequar	nca of):			
death death e atten	Part II. Other significant conditions contributing to d	leath but not resulting in the under	erlying cause given in Pert I.	23b. Did t	obacco uss contributs	to the cause of death?
P.O. thet the detach detach				101	/ss 21√No 3□P	robably 4 Unknown
ev requir				24a. Was perfo	med?	Were autopsy findings available prior to completion of cause of death?
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it it it it it it it it it it it it it i	25. Was case referred to medical examiner?	V	Other	ath (Check only o		
T SE SE	1 Yes 2 No 1 27. Manner of Death 28a. Dete	Inpatient 2 ER/Outpetient of Injury 28b. Time of		· · · · · · · · · · · · · · · · · · ·	enca 8 Other (Spe	ecity)
E 5	1 Netural 5 Pending (Mor 2 Accident Invastigation 3 Suicide 6 Could not be 28e. Plac	e of Injury - At home, farm, street	M 28c. Injury at Work? 1 ☐ Yes 2 ☐ No , factory, office		itreet and Number or R	ural Route Number,
DIVISIO To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the 1	29a. Certifier 1 Certifying Physician; To the	e best of my knowledge, deeth or	ocurred at the time, dete end plece	e, end due to the d	cause(s) and manner a	
the Hospi in 24 hou the Funer apletely fill	one) and mar	pasts of examination and/or investment stated.	tigation, in my opinion, deeth occi			
Tother	29b. Signatura and title of certifiar	Thim	29c. License number D 00 3 9 5 4		29d. Date signed (Mon	n, Day, Year)
(10)	30. Nama and address of person who completed cau	se of death (Item 23a) (Type, Pri			192110	
	Cedric Poku-Dankwah, M.		entral Ave. Lan	dover, M	D 20785	
State	31. Date filed (Month, Day, Year)	Registrar's Signatura	1			

DHMH 16 Rsv 6/95



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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	. 1						

State of Maryland / Department of Health and Mental Hygiene

					(Certifica	te of	Death		Reg. No.	3	6449	
Dhualaian	Decedent's Name (First, Middle, Last)								2. Dete of D Month	eath Dev	Year	3. Time of Death	
Physician /Medical	Hazel Whitman Anderson								Nov.	4, 200		11:10 am	
Examiner	4e Facility Neme (If not institution, give street and number)							4b. City, Town, or Location of Death 4c. County of					
0	Future Care Chesapeake Arnold									Anne			
Funeral Director	5. Sociel Security Number 6. Sex 1 M 2 ★ 7. Age (In yrs. Ia 1 M 2 ★ 85					Months	Deys	Hours N	lin. 8. Date of B (Month, D Apr 28	ay, Year)	9. Birthpl Count Nort	ace (Stete or Foreign hy) h Carolina	
D	Usual Residence of I	10b. County		10c. C	ity, Town	or Location					10	Od. Inside City Limits	
Maryl Her sho fled a		Anne A	rundel			Park						1 ☐ Yes 2 🛣 No	
death with the Maryla ms 23e or 28e-f sho must be notified at heral Director	10e. Street and Num 320 Stone		Orive				ip Code			10g. Citizen of W USA	/het Count	ry?	
rs sher desti r, or hems 2 xaminer mu by Funera	11. Marital Status 1 ☐ Nevar Marrie 3 ☑ Widowed 4		Armed Fo	12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates:				dispenic Origin? an, Mexican, Pu Specify:	(Specify Yes or Nerto Rican, etc.)				
Mathera Elical E		Education grada completed)				Decedent's Usuel Occupation (Give kind of work done during most of working)			16b. Kind of Bu	b. Kind of Business/Industry			
ed within typiens wer then ft, the Med	Elementery/Secon			College (1-4or 5+)			Homemaker			Home			
	17, Father's Nema (/	First, Middla, L	est)		1	1011enax	er	18. Mother's	Name (First, Middle	(First, Middle, Meiden Surneme)			
Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Me	Ashley Ro	bert W	nitman					Chris	stannie Matthews				
ath and National Street Institute of Tale men of Tale men or treatmen	19e. Informent's Ner Mitchell					-			Rural Route Num			Code)	
Pages 1 a nant of He int: If Item iny or othe	20a. Method of Dispo 1 Burlel 2 C 4 Donetion	Cremetion	3 □Removel from ecify)	Stete Wa	Pleca of Cometery,	Disposition (No. cremetory or Memoria	other ple	ce) ark	Nov 8,	Goldsbo			
Departit Departit Imports any ink	21. Signeture of Eur	urel Sarvice L	censee			Barra 495 G	nd Addre	& Sons, Ritchie	P.A. Ser Hwy, Ser	verna Pai verna Pai	ck Fu	neral Home D 21146	
	23a. Part1. Entar the shock, or heart	e disease, or o	omplications that only one cause on e	caused the dea	ith. Do no						1	Approximata Interval Between	
Physician / /Medical	Immediate Ceuse (F			Λ								Onset and Death	
Examiner	disease or condition resulting in deeth)	a	Hu	Mys	con	did	mond	tion		nours			
Je J				Due to (or es e co	onsequence of	j.		0		- !		
cate be executed physician and s the burial-transit													
death certificate be attending physicis of for use as the bu	thet initieted events resulting in death) La	ast	d	Due to (or es e co	nsequenca of	:			1.53	1		
d for u	Part II Other eignific	cent condition	e contributing to d	eath but not re	eulting in t	the underlying	cause ok	ven in Part I	23h Die	i tobacco usa cor	atribute to	the cause of death?	
that the death cert ad by the attendin detached for use Physician/W	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Hypertension Alchemers dementa									1 Yes 2 No 3 Probably 4 U			
To the Nospital or Attending Physician: The law requires that the death certifications after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as Medical Certification: To Be Completed by Physician/Me	A1	Theim	er's de	menti	a					s en eutopsy formed?	ava	ere autopsy lindings allable prior to appletion of cause deeth?	
The laste has page									10	Yes 2 No	10	Yes 2□ No	
elan: entific ector.	25. Wes case referre	ed to medical					1.00		Deeth (Check only	one)			
hysic this call dire	1 ☐ Yes 2 💢 N				-	petient 3 C	OA	-	g Home 5 Re)	
is or Attending P is after death. Bi Director: After t ed in by the funera Certification:	27. Manner of Deeth 28a. Dete of Injury 28b. Time of Injury 28c. Injury et Work? 28c. Accident 28c. Injury et Work? 1 Yes 2 No									28d. Describe how Injury occurred			
rs after d al Direct led in by	3 Suicide 4 Homicide	determin	289. PIBCE	of Injury - At I ing, etc. (Spec	nome, lem	n, street, lecto	ory, offica			(Street end Numb own, Stete)	er or Rure	Route Number,	
in 24 hours the Funer pletely fill			caminer: On the b			or Investigation	n, in my	opinion, deeth o	ece, end due to th eccurred et the time	, dete end place,	and due to	the ceuse(s)	
To the Com	29b. Signatura and t	itla of certifier	Lone	ME	6		D-1	sa number 40521		November 1	on 5	,2000	
	30. Neme and addre		ho completed caus		m 23a) (T	ype, Print)	845	on Bur	ood Rod	21229	20	5	
State Registrar	31. Data filed (Month	OV 08	2000 32. F	Registrar's Sign	etura	6	Con	the					

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State of Maryland / Department of Health and Mental Hygiene 00 361,50

			Ce	ertificate	of Death	R	eg. No.	00430		
ton	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month		3. Time of Dea		
ian ical	William Herbert B	October								
ner	4a Facility Name (If not institution, give				4b. City, Town, or	Location of Death	4c. County	of Death		
	Corsica Hills Nurs				Centrevi			en Anne's		
	5. Social Security Number 6. Sec	7. Age	(In yrs. last birthday	y) If Under 1 Months I	Year If Under 24 Hr. Days Hours Mir	. (Month, Day	Year)	Birthplace (State or For Country)		
-	212-03-4780		88 Yrs.			August	5,1912	Rock Hall, M		
	10a. State 10b. County		10c. City, Town or I	Location				10d. Inside City Lin		
tor	Maryland Kent		Rock H	a11				↑ Yes 2		
Directo	10e. Street and Number			10f. Zip C	ode	1	0g. Citizen of W	/hat Country?		
	5768 South Hawtho		USA							
Funeral		12. Was Decedent E	2. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spetif Yes, specify Cuban, Mexican, Puerto F			Specify Yes or No-	- 14. Race - American Indian, Black, White, etc.			
1000	1 Never Married 2 Married	1 ☐ Yes 2 No If Yas, Give 1 ☐ Yes 2 No Specify: Year or Dates:				Spe				
d by	3 Widowed 4 Divorced							White		
Completed	15. Decedent's Edu (Specify only highest grade		16a. Dec	edent's Usual (Occupation done during most of wi retired)	working 16b. Kind of Business/Industry				
duc	Elementary/Secondary (0-12)	College (1-4or 5-	+)		remou)		Tourt ilo	a/Mafa		
	17. Father's Name (First, Middle, Last)		Foreman Textiles/Mgfr							
To Be	John Robert Batch	elor			Edith M	buriel Elb	riel Elbourn			
-	19a. Informant's Name/Relationship (Ty		19b. Ma	iting Address (5			aral Route Number, City or Town, State, Zip Code)			
	Frances E. Batchel	or	5768	South	Hawthorne	Ave. Rock	Hall,	MD 21661		
	20a. Method of Disposition	HEX -	20h Place of Dist		of			City or Town, State		
8	1 GBurial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State			Cemetery	10/28/200	O Rock	Hall MD		
	21. Signature of Funeral Service License	99 /			Address of Facility	10/20/200	O ROCK	TIGHT, TID		
	1 Kick to	2/18/	1	ellows,	Helfenbei	n, & Newr	am Fune	ral Home PA		
	Fellows, Helfenbein, & Newnam Funeral Home PA 130 Speer Rd. Chestertown, MD 21620 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate Interval Between									
	snock, or near railure. List only or	ie cause on each in	0.					Intervat Between Onset and Deatl		
	Immediate Cause (Final disease or condition resulting in death) a. Confos 745 Hugh Fmicht							6uson		
	resulting in death)		Due to (or as a cons	equence of):	1 micolit					
Examiner		14400	nonsuy					10yomi		
жаш	Sequentially list conditions,		Due to (or as a cons							
	Sequentially list conditions, if any, teading to immediate ceuse. Enter Underlying Cause (Disease or Injury c.									
edicai	that initiated events resulting in death) Last									
5										
Physician/										
9	Part II. Other significant conditions con	tributing to death bu	se given in Part I.	23b. Did to	old tobacco use contribute to the cause of deat					
2							Yss 2216 3 Probably 4 Unkn			
						1 U Y	SS ZEPNO			
þ						24a. Was a	n autopsy	24b. Were autopsy findin		
by							n autopsy	available prior to completion of cause		
þ						24a. Was a perfori	n autopsy med?	available prior to completion of cause of death?		
e Completed by	25. Was case referred to medical				26 Piace of D	24a. Was a perfor	n autopsy med?	available prior to completion of cause		
o Be Completed by	examiner?	lospitai: 1 □ Inpatier	nt 2 ER/Outpati	ent 3∏ DOA	Other	24a. Was a perion 1 Yo	n autopsy med? es 2 □ N o	available prior to completion of cause of death? 1 Yes 2 No		
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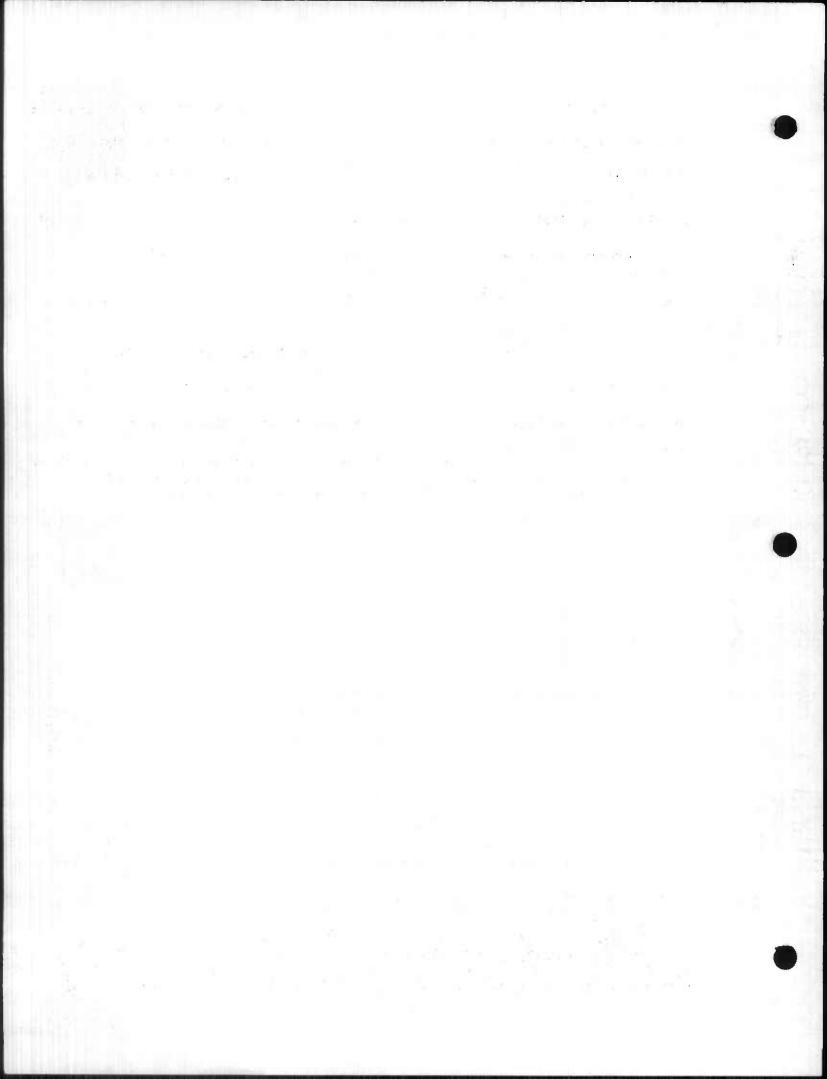
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State of Maryland / Department of Health and Mental Hygiene 0 0 3645

					Cei	rtificate d	of Deati	h		Reg. No.) 0	0401
		1. Decedant's Nama (First, Middla, L.	ist)	Q. T			11/2		2. Data of Da	ath		3. Tima of Desth
Physici /Medi		Helen Loretta BUC	CK						Month October	Day 28, 20	Yaar 00	2:55 p.m
Examir		4a. Facility Nama (If not institution, gi	a street and number	r)			4b. City, 7	Town, or L	ocation of Desti			
		Homewood Retireme	ent Center						sport	Wash	ingto	n
Funeral Director			Sex 7. A 1 □ M 2 ◯ F	nga (In yrs. las 97	Yrs.	Months Da	aar If Unde	Min.	(Month, Da	th y, Year) 17,1903	9. Birthpl Count Mary	leca (Stata or Foraign try) Land
anyland show id.at		10a. Stata 10b. County		10c. City,	Town or Lo	cation					10	0d. Insida City Limits
Many Many	to	Maryland Washin	igton		На	gersto	vn					1 ☐ Yas 200 No
7 28g	Director	10e. Street and Number				10f. Zlp Cod	ia.			10g. Citizan of	What Count	try?
1 m m		11238 Greenmount	Avenue			217	40			USA		
21215-0020 d within 72 hours atter dos giere. r than "natural", or thems the Medical Examiner my	by Funeral	11. Marital Status 1 ☐ Nevar Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forcas 1 Yas 2 If Yas, Giva Yaar or Datas:	? No		Was Decedant If Yas, specify (1 ☐ Yas 2 ☑	Cuban, Maxic	an, Puarto	pecify Yas or No Rican, atc.)		ce - Amarice ck, Whita, a	
72 Tr. Tr. Tr. Tr. Tr. Tr. Tr. Tr. Tr. Tr.	Completed	15. Decedant's E (Specify only highast gr			16a. Deced	dant's Usual Ockind of work do	cupation	nst of work	cina	16b. Kind of B	usinass/Ind	lustry
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Maryland dis should be tile th and Mertal Hy 7 is marked othe traumatic event.	To Be	17. Fathar's Nama (First, Middla, Las Frederick Whitmo					18. Mot		y L. Sh	Maiden Suman uff	18)	
2 sho		19e. Informant's Name/Relationship	Type, Print)		19b. Meilir	ng Address (St	reet and Num	ber or Ru	ral Routa Numbe	er, City or Town,	Stata, Zip	Code)
CON L		Pat A. Buck - day	ighter		1123	88 Green	nmount	Ave.	, Hager	stown,	Md. 2	1740
altimore, mil. Pages 1 ar partment of Hea portant: if Ihem. y injury or other		20a. Mathod of Disposition 1 ☐ Buriai 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Content of the Con		а сеп	natary, crar	sition (Nama on natory or other 1 Cemet	placa)	1:	Data 1/2/00	Hagers		wn, Stata ,Maryland
Ball permit Depart Import emy in		21. Signature of Eunarai Sarvice Lica	nsee	-	//	Nama and Ad 15 E. W				FUNERAL rstown,		21740
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v requ	Completed b								24a. Was perfo	an autopsy med?	sva	ere autopsy findings allabla prior to mplation of causa daath?
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DIVISION OF To the Hospital or Attending Phy within 24 hours effer death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	27. Menper of Death 1 Whatural 2 Accident 3 Suicida 4 Homicida 6 Could not to datermined	e 28a. Place of Ir	njury - At home	Bb. Tima of fnjury a, farm, str	М	njuryat Work? 1 □ Yas 2 [□No	28f. Location (now injury occur		l Route Number,
Hospital or 24 hours effe Funeral Dirustely filled in			ysician: To the best	etc. (Specify)	edne deeth	occurred at th	a tima data s	and place	City or Ton		enner ss st	ated
Hon 124 h	edicai	(Check only 2 Medical Example)	ninar: On the basis of	of axamination	and/or in	vestigetion, in n	ny opinion, de	eth occur	rad at tha tima,	data and placa,	and dua to	tha cause(s)
To the within 2 To the comple	M	29b. Signature and the of certifiar		Y		29c. Li	eosa numbe	r		29d. Data signe	d (Month, E	Dsy, Year)
		1 Jackt 1	Aux 10	Sa No	160	an	1)(7	06	7	10/30	160	00)
		30. Nama and addrass of person who	complated cause of	death (Itam 2	За) (Туре,	Printy	24	AI	a A	100	ren 1	Ind
C.		31. Deta filad (Month, Day, Year)	1 (32 Regiet	trar's Signatur	17,) JOUN (11000	110	- 114	000/0	1	0
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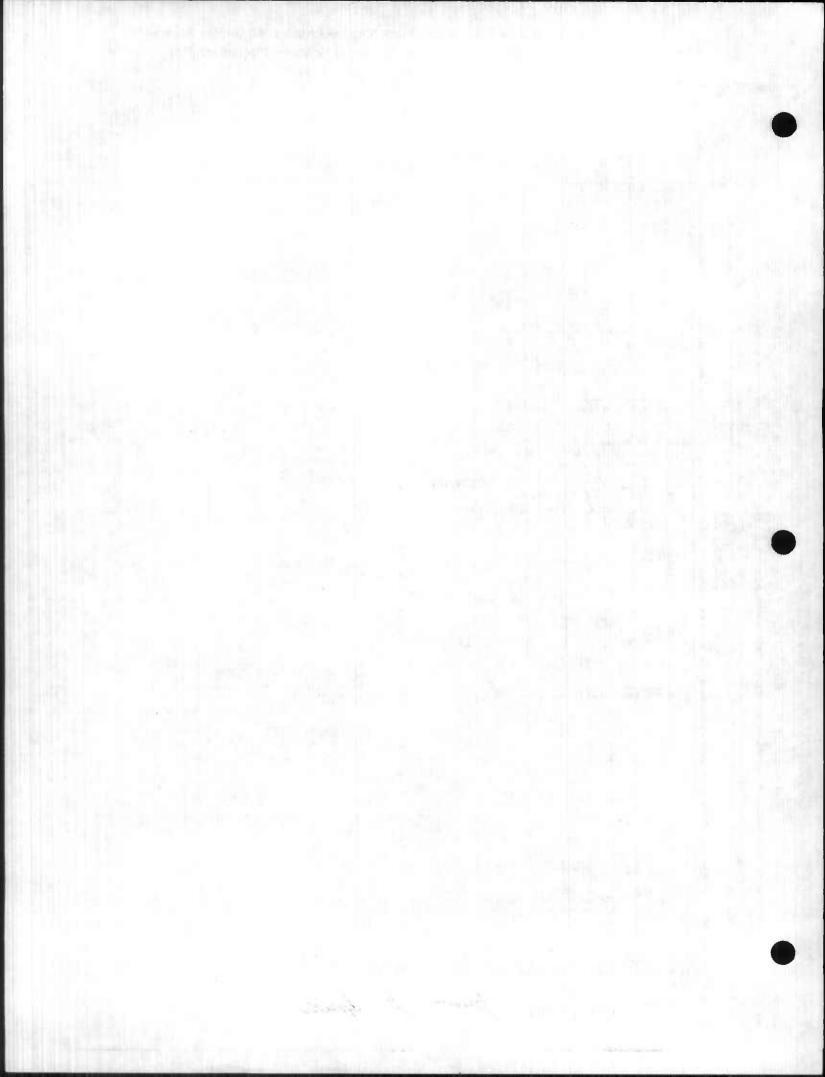
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

		Decedent's Neme (First, Middle, La	State of Maryla	nd / Departmen Certificat				Reg. No.	0 36452
	ician			BROOKS			Month	Day	Year 1255
	dical niner	4a Facility Name (If not institution, given PENINSULA REGIONAL	re street and number)		4	b. City, Town, or SALISE	Location of Death	4c. County	
Funer Direct		n/a	Sex 7. Age (In yrs	Vrs. If Under Months	1 Year Deys	If Under 24 Hrs Hours Min 4(. (Month, De		Birthplace (State or Foreign Country) Maryland
During Man		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Location					10d. Inside City Limits
r death with the Maryla erre 23a or 28a-f shor er must be notified at	tor	Maryland Wicomic	co	Salisbury					1 ☐ Yes 2 ☐ No
th the or 28	Directo	10e. Street and Number		10f. Zip	Code			10g. Citizen of V	What Country?
ath w	E	209 E. Isabella	· -		1804			USA	
_ 2 = 0	by Fune	11. Marital Stetus 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	J.S. 13. Was Decer If Yes, spec		spanic Origin? (in, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	Blac	e - American Indian, ck, White, etc.
Maryland 21215-0020 it should be filled within 72 hours at the and Merital Hygiene. The marked other than "natural", or traumatic event, the Medical Exami-	Completed	15. Decedent's Ed (Specify only highest grade) Elementery/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	18a. Decedent's Usua (Give kind of wo life. DO NOT us	al Occupa rk done d se retired	ation luning most of wo	orking	16b, Kind of Bi	usiness/Industry
d 21		n/a 17. Father's Name (First, Middle, Last,	n/a	n/a		18 Mother's No	me (First, Middle,	n/a	24
d be d be d be d be d be d be d be d be	To Be	Unknown					a Lee Br		10)
Z shook and Mo is mark	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address	(Street				Stete, Zip Code)
altimore, Mimit. Pages 1 and 2 partment of Health a portent: If Hem 27 is y Injury or other trea.		Tamara Lee Brooks 20a. Method of Disposition 1 □ Burief 2 □ Cremation 3 □	20b.	209 E. Place of Disposition (Nercemetery, cremetory or d		e)	, Salisk	20c. Location -	City or Town, State
Him Pa		4 □ Donation 5 □ Other (Specifical Service Licer	ACCUSED TO THE REAL PROPERTY.	lisbury Cre		- 1	10/14/00		bury, MD
Depa Depa	OUCS	23a. Part1. Enter the disease, or com	(Domago	501 Sn	ow H	ill Rd.,	Salisbu	ry, MD	1 Association 21804 Approximate Interval Between
death certificate be executed with the same of for use as the burial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Undertying Cause (Disease or Injury that initiated events resulting in death) Last	b. incomplete	or as a consequence of):	e for	ètus_			
Box (eath certif	lan/		d						
O, the	Physician/Me	Part II. Other algnificant conditions of	contributing to death but not re-	sulting in the underlying o	ause giv	en in Part I.	23b. Did	-1	antribute to the cause of death? 3 Probably 4 Unknown
Records, P is law requires that shes been signed b ge 2 should be dete	Completed by			1467.41				an eutopsy med?	24b. Wera autopsy findings available prior to completion of cause of death?
The law ate has b page 2 s	Comp						10	Yes 2 No	1 ☐ Yes 2 ☐ No
Vital lician: The certificate frector, per	Be	25. Was case referred to medicel examiner?	Hoenital:		1045	-	eath (Check only o	one)	
O Phys ral di	10	1 ☐ Yes 2 No 27. Menner of Death	Hospitel: 1 Minpatient 2 L	ER/Outpatient 3□ D0		4 Inursing	Home 5 Resi	dence 6 Oth	
Sion landing leath. or: After the fune	Certification:	1 Naturel 5 Pending 2 Accident investigation 3 Suicide 6 Could not b	(Month, Dey Year)	М		k? Yes 2 □ No			ber or Rurel Route Number,
DIVI		4 Homicide determined	28e. Plece of Injury - At h building, etc. (Speci				City or To	vn, State)	
To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kni niner: On the basis of examini end menner stated.	owledge, deeth occurred etion and/or investigation	at the tim , in my of	ne, date and place pinion, deeth occ	e, and due to the turred at the time,	cause(s) and made and place,	anner es stated and due to the cause(s)
To the within 2 To the	Me	29b. Signeture and title of certifier	1	1 290	c. License	e number		29d. Date signe	d (Month, Dey, Year)
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		Pennsua OB-G	completed ceuse of death (Ite YN 314 W	Carroll St	- 8	Usbury	MD	21801	
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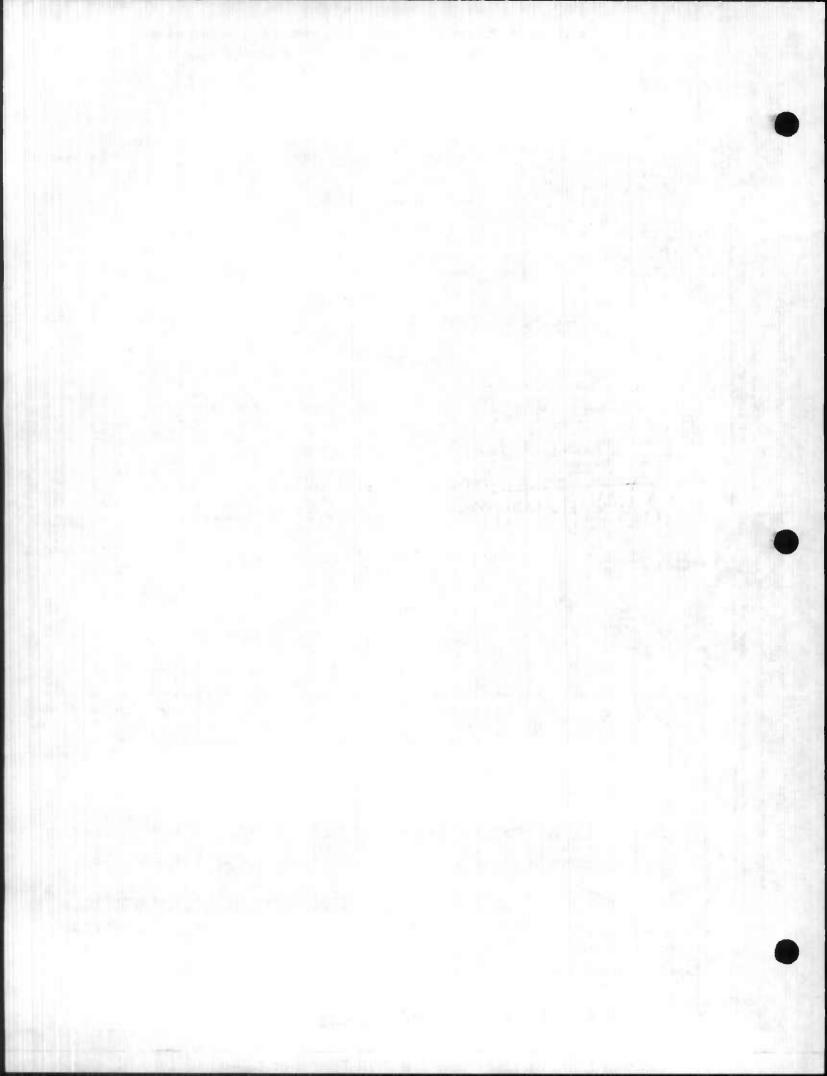
Baby Boy Tamara Brooks



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State of Maryland / Department of Health and Mental Hygiene 00 36453

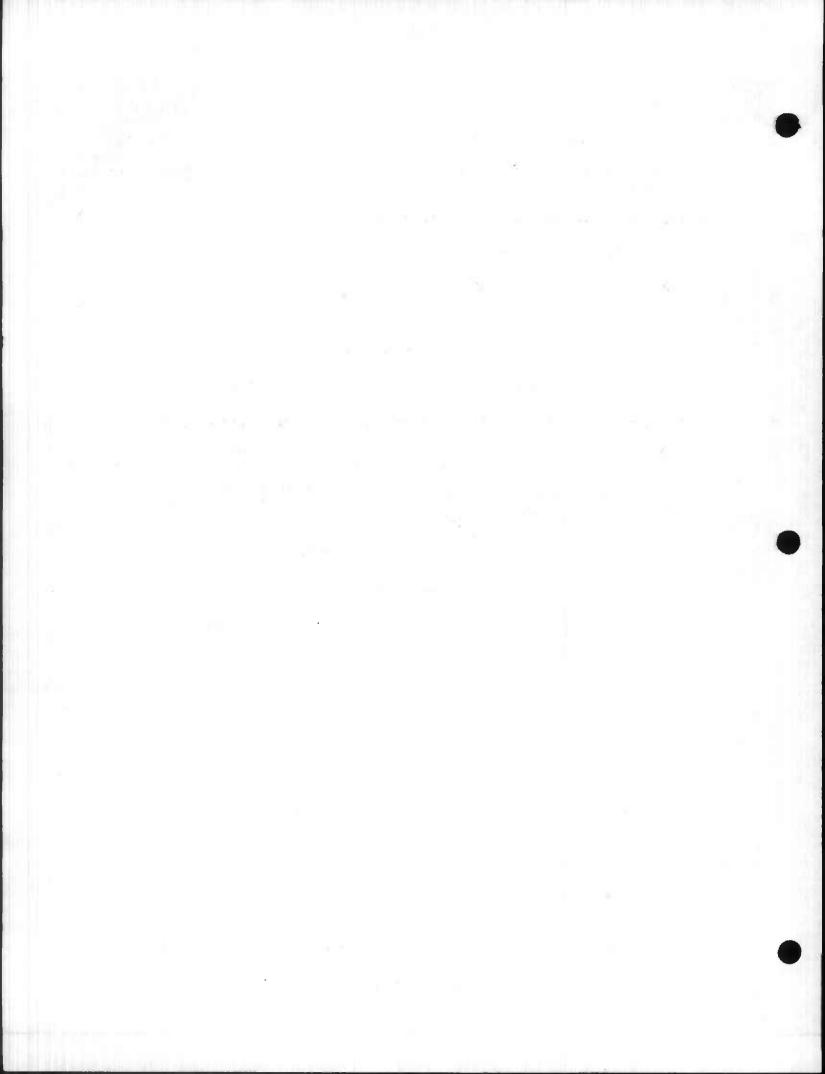
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Physician /Medical	PAMELA	ANN	BOZMAN					Octobe	R 27 2	0006	1350
Examiner	4a Facility Name (If not institution, give				1	b. City, Tow	m, or Lo	cation of Death	4c. County	of Death	
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Funeral Director	212-72-2027		(In yrs. lest birthday 12 Yrs.	Months	Days	Hours	Min.	8. Date of Bird (Month, Da	13,1958	9. Birthp	lace (Stala or For
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be nutitied at	Maryland Somers	set	3 - 3 -	ess Ar							1 Yes 2□
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opiene. The Medical Completed	15. Decedent's E (Specify only highest gn Elementary/Secondery (0-12)		(Give	edent's Usua e kind of work DO NOT use USEWI f	k done e retired	ation during most 1)	of workir	ng	16b. Kind of Bu		dustry
Mental Hygerkad other effe event.	17. Father's Name (First, Middle, Last Richard Wallace	Cleveland					's Neme		Meiden Sumem Travis	10)	
alth and 27 is ma ir treasm	19a. Informant's Name/Relationship (Margaret J. Drewei			-					er, City or Town, Leld, MD		
ant of Ha nt. If Nam ry or othe	20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specia		20b. Place of Disposements, cre Springhil	metory or ot	har pled		נו	Date /1/00	20c. Location - Hebror		wn, State
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hes E								10	Yes 2 No		death?
certificata rector, pag	25. Was case referred to medical					26 Plene	of Death	(Check only		1	Tes Zeino
	examiner? 1 Yes 2 No	Hospital:	t 2 ER/Outpatie	ent 3 DO	A Oth	or.			dence 8 Oth	er (Specif	v)
where the	27. Manner of Death 1. Natural 5 Pending 2 Accident Invastigatio 3 Suicide 6 Could not b 4 Homicide determined	0 00 Dian (1-in	Year) Injury	М			10	28d. Describe	how injury occur	red	
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State of Maryland / Department of Health and Mental Hygiene

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neral			Sax 1□M 2XF	7. Aga (II	n yrs. last bir	thday)_ Yrs.	If Under 1 Year Months Days		lin. (Month, D	rth ay, Year)	9. Birth	placa (Stata or Foreign
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Be Completed by Funeral Director	2	10e. Street and Number					10f. Zip Coda			10g. Citizan of	What Cour	ntry?
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		1 Burlal 2 ☐ Cremation 3		Stata	cemata/	y, crema	ition (Name of atory or othar pla	ice)	10/6/00	200. Location		
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OLICE		21. Signature of Funaral Sarvion Lic	ensee			St	Nama and Addr.	ass of Facility Funera	1 Home			
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by P									'	148 20140	3 110	DECITY 420 OHKHOWN
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jet									реп	ormad?	CO	vallabla prior to emplation of causa daath?
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To Be		axaminar? 1 ☐ Yas 2 ☑ No	Hospital:	Inpetiant	2□ ER/Ou	tnotiont	3□ DOA Ot	har .	Death <i>(Check</i> on <i>ly</i> g Homa 5 ☐ Ras		thar (Casai	6.1
		27. Manner of Death	28a. Data	of Injury	28b. T	Time of	28c. Inju			how Injury occi		ry)
tio		1 Natural 5 ☐ Panding 2 ☐ Accidant invastigat		nth, Day Ye	par) Ir	njury		rk?]Yas 2 □ No				
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ert		4 Homicide	buildi	ing, etc. (S	ipecity)				City or 10	wn, State)		
		29a. Certifier 1 Certifying	hysician: To the	best of m	y knowledge	, death	occurred at the ti	me, date and pla	ace, and due to the	cause(s) and r	nanner as s	stated.
edicai		(Check only 2 Medical Expone)	aminer: On the b and man	asis of exa inar stated.	amination and	d/or Inva	stigation, in my	opinion, daath o	ccurred at tha time	, date and place	, and due to	o tha cause(s)
×		29b. Signatura and title of cartifiar					29c. Lican	sa number		29d. Date sign		Day, Year)
		NWKIN					04	70 94		10/4	100	
	-	30. Nama and addrass of person wh	o complated caus	sa of daath	(Itam 23a) ((Type, P	rint)					
		4.15.	MLFOHD	STREET				MD 219	04			
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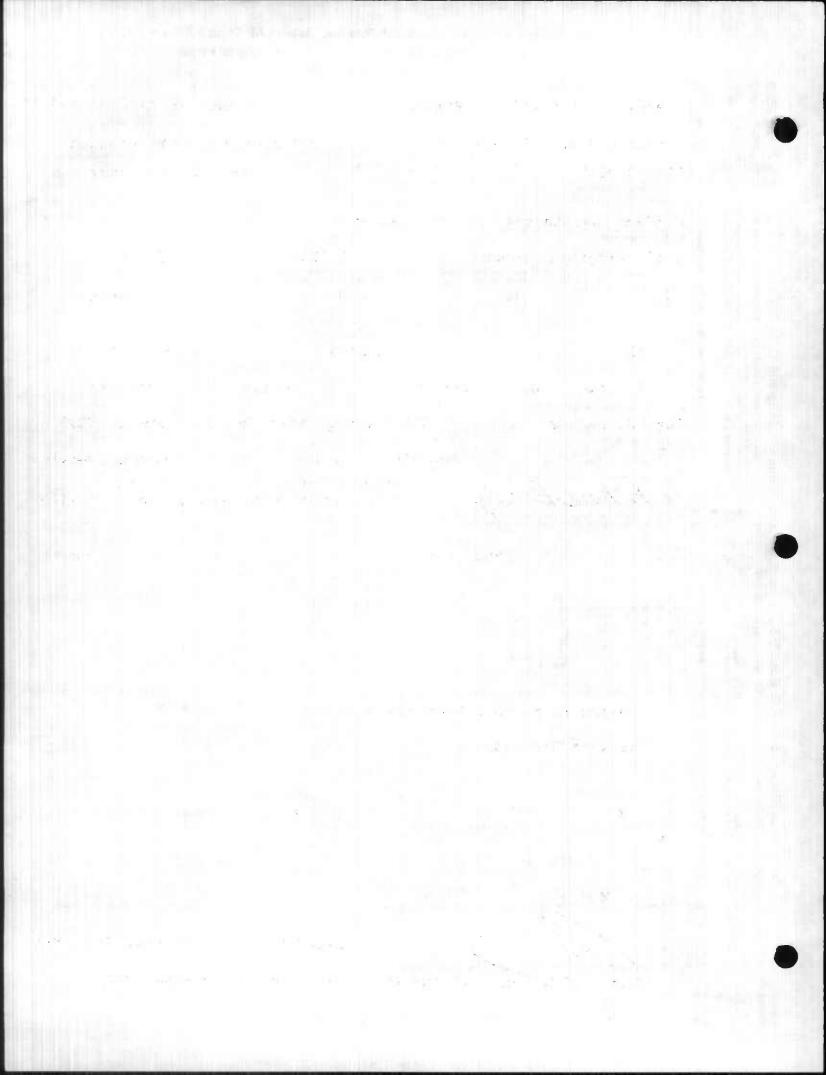


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State of Maryland / Department of Health and Mental Hygiene

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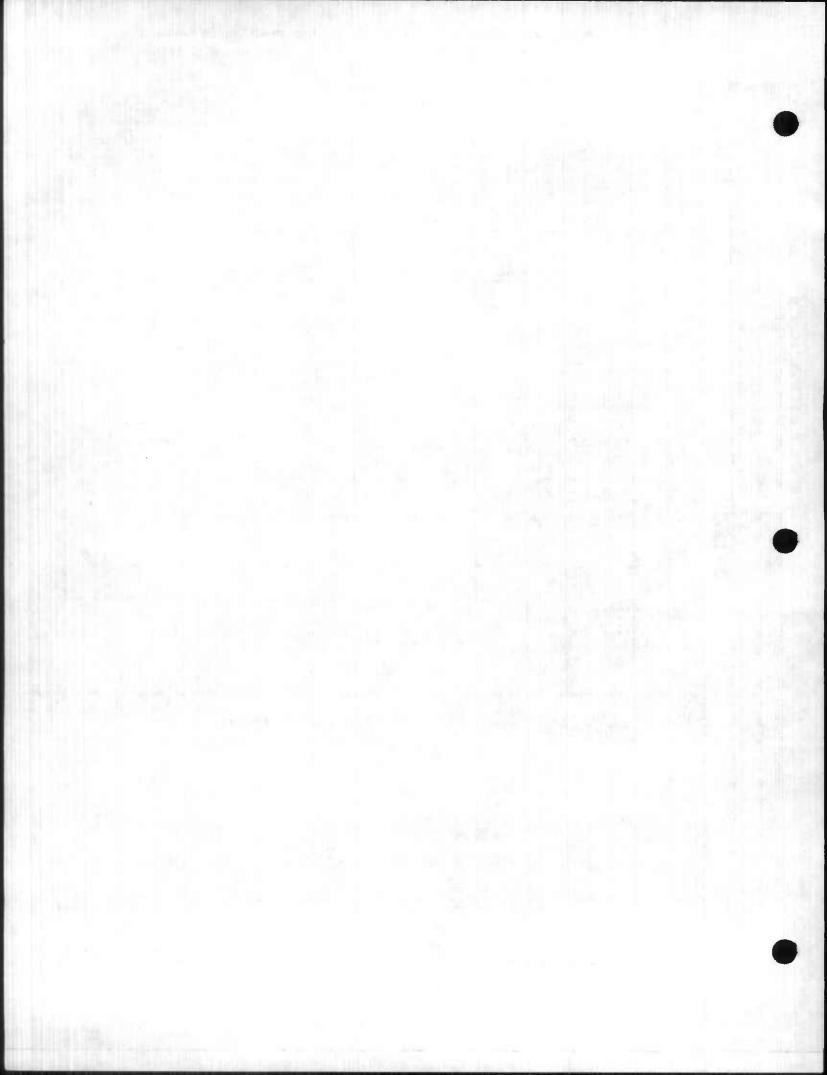
Physician - /Medical Examiner					00,	111100		Death			leg. No.		
- /Medical		Decedent's Name (First, Middle, La	st)					THE R		2. Dete of Dee		V	3. Time of Death
		MARY LUC	ILLE	BEN	DER					October	25, 20	OO Yeer	10:45 AM
	40	Facility Name (If not institution, give	re street and number)				4b. City, To	wn, or Lo	ocation of Death	4c. County	of Death	
	H	Homewood at	Williams	sport				Will	iam	sport	Was	hing	iton
Funeral	5.	Sociel Security Number 6. S	Sex 7. A	ge (In yrs. la	st birthdey)		er 1 Year	If Under	24 Hrs.	8. Date of Birth	1	9. Birthp	place (Stete or Foreign
Director	12	214-09-0065	I□M 2 X 0F	95	Yrs.	Months	Days	Hours	Min.	May 14,	1905	Mar	yland
D	-	suai Residence of Decedenf											
anylen ehow	10	De. Sfafe 10b. County		10c. City	Town or Lo	cation						1	0d. Inside City Limits
Man	1	Maryland Washi	ngton	Wi	illia	msp	ort						1 Yes 2 No
or 28a-f	10	De. Sfreet end Number				10f. Z	ip Code				10g. Citizen of V	What Cour	nfry?
th with	1	16505 Virginia	Avenue				217	95			U.S	. A.	
ifter deeth with the Maryland r items 23s or 28s-f show ing must be notified. Funeral Director	11	. Merital Status	12. Was Deceden	Ever in U,S	13.	Was Dec			igin? (Spe	ecify Yes or No- Rican, etc.)		e - Americ	
		1 ☐ Never Married 2 ☐ Married	Armed Forces	No		i ves, sp 1 □ Yes				rican, etc.)		ck, White,	
ors	2	X□ Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1 Ll Yes	2 KN NO	Specify:			Specify	Whi	te
led within 72 hours tygiens. Per than "natural; It, the Wod call Completed by	3	15. Decedent's E	ducation		16a. Deced	dent's Us	uel Occup	etion	4 = f		16b. Kind of B	usiness/Ind	dustry
within 7 ene. than "n	-	(Specify only highest green (0-12)	College (1-4or	54)	life.	DO NOT	use retire	during mos	it or work	ing			
jena.	5	Elementery/Secondery (0-12)	Conlege (1 401	01,		Hom	emak	er			0wn	Home	
tal Hygin d other ovent, II	17	7. Father's Name (First, Middle, Last,)					18. Mothe	er's Name	(First, Middle,	Meiden Sumen	10)	
should be ad Mental marked o matic ev	3	William	G.	Nehr	ing			Am	neli	а	Ni	erma	n
2 short and N and N is mail		9a. Informant's Name/Relationship (Type, Print)		19b. Meilir	ng Addres	ss (Street	end Numb	er or Rure	el Route Numbe	r, City or Town,	Stete, Zip	Code)
end 2 saith a n 27 io er trau	10	Carl J. Bender	Son		5071	Cole	ridae	e Driv	ve. F	airfax,	Virgin	nia	22032
- H P P		e. Method of Disposition		20b. Ple	ace of Dispo	stion (N	eme of			Date	20c. Location -		own, State
		1 N Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		9	e Hil]				10-28	3-2000	Haners	town	Maryland
Departmer Departmer Important: any injury once.	2	Signature of Funeral Service Licer		1103				y			-		ridi y idild
Depariment in police.		Dhan	Q 1							uneral			
	+	N. Meles	many									wn, M	ld. 21740
ALC: U	2	3a. Part1. Enter the disease, or comehock, or heert failure. List only	one cause on each	d the death. line.	Do not ent	er the mo	de of dyle	ng, such as	cardiac	or respiretory en	rest,	1	Approximate intervel Between Onset and Death
Physician	1.											1	Oriset and Death
/Medical Examiner	di	nmediete Cause (Finel isease or condition	Pne	umon:	ia							1	weeks
		esulting in death)		Due to (or	as a consec	quenca of):					1	
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ien g		equentially list conditions, any, leading to Immediate ause. Enter Underlying ause (Disease or injury let initiated events											
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the tac		Severe Al	zheimers	Demi	entia					101	108 2 No	3 Pro	bably 4 Unknown
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been si should t	3	Seizure D	isorder							24a. Was a	an autopsy med?	24b. W	ere autopsy findings allable prior fo
aw requisite been 2 should	-	3012010 D	1301001									co	mpietion of cause death?
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Physic this coral direction T. To		7. Menner of Death		ient 2 E	28b. Time of					28d. Describe h			9)
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to the Hospital or within 24 hours aft To the Funeral Di completaly filled in Medical Cer		96. Signature and title of efficilies)			D -	2680	6		Octobe	er 2	5, 2000
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To the Hospital or Attendi within 24 hours after Geath. To the Funeral Director: A completaly illed in by the it Medical Certificati	30	1///	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s							own, Ma:			5, 2000



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State of Maryland / Department of Health and Mental Hygiene 00 36456

			Certificate	of Death	R	leg. No.		
Dhoodain	1. Decedent's Name (First, Middla, Last)		A Marie	MI HERVA	2. Date of Dea		Year	3. Tima of Death
Physician /Medical	BEGINA CAR	OL BEAY	VER		QC1.	27	2000	1:50 pm
Examiner	4a Facility Name (If not institution, givas			4b. City, Town, or I		4c. County		
<u> </u>	Western Maryland I			Hagerste			ningto	
Funeral Director	5. Social Security Number 6. Sex 212-50-9904	7. Age (In yrs. 5 2	Yrs. Months D		(Month, Day	, 1948		ce (Stata or Foraign y) land
p Bu	10a. Stata 10b. County	10c. City	y, Town or Location		-		10	d. Inside City Limits
Mary Heat	Maryland Washing	ton H	agerstown					1 Yas 2 □ No
or 28a-1 A nothin	10e. Street and Number		10f. Zip Co	de	1	l 0g. Citizen of W	hat Countr	y?
A LINE	1500 Pennsylvan	ia Avenue	21	742		U.S.	Α.	
in after count with the war in a standard to the standard to the standard to the standard by Funeral Director	11. Meritat Status 1 Never Merried 2 Merried 3 Widowed 4 Divorced	2. Wes Decedent Ever in U, Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	S. 13. Was Deceden If Yes, specify	t of Hispanic Origin? (S Cuban, Mexican, Puert No Specify:	pecify Yes or No- o Rican, etc.)	14. Race Black Specify:	- America c, White, et	tc.
	15. Decedent's Educ		16a. Decedent's Usual C	ccupation	400	16b. Kind of Bu	siness/Indu	ustry
the Medical	(Specify only highast grada Elementary/Secondary (0-12)	College (1-4or 5+)	16a. Decedent's Usual C (Giva kind of work of lifa. DO NOT usa r		king			
Con men	12		Store Room			Departm		tore
Be age	17. Father's Neme (First, Middla, Last)				ne (First, Middla,			- 6.7
To To	3		Beaver	Teres		nes		phy
asith and 27 is m ar traum	19a. Informant's Name/Reletionship (Type David E. Beaver Si	. Brother		ansville Ro		ansvill	e, Md	. 21767
ant of He mt. If Berr ny or oth	20a. Method of Disposition 1 Disposition 1 Disposition 2 Cremetion 3 Real Disposition 4 Donation 5 Other (Specify)	emovel from State	Place of Disposition (Nama Tematery, crematory or othe est Haven Cem		-31-2000	Hagers		m, State , Marylanc
Departri Importa any inju	21. Signature of Funeral Service License R. Rael H	Brady		ddress of Facility Coffman I				d. 21740
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/Medical	Immediate Cause (Finel disease or condition	Y HOLL	144116					dais
xaminer	resulting in death)	Due to (c	or as a consequence of):					1
- F							1	- /
hysician and the burial-transit	Sequentially list conditions,	Due to (o	or as a consequence of):			45147	1	
	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury							
	that initiated events resulting in death) Lest	Due to (o	r as a consequence of):					
2 .	L.						i	
for use				MULTERINIT			1	
gned by the attendir be deteched for use by Physician/N	Part It. Other significant conditions con	ributing to death but not res	ulting In the underlying caus	se given in Part I.		3 /		the cause of death?
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page 2 should be deteched for use		- CALA			24a Was	an autopsy	24b. We	re autopsy findings
should should					perlo	med?	ava	ilable prior to
page 2 s						20		eath?
certificate hes rector, page 2 Be Comp					1 U Y	17	10	Yes 20 No
	25. Was case referred to medicat examiner?	ospitat	500	Other V	eth (Check only o		- 10	
£ 70	1 Yes 2 No	1 inpatient 2		41- Nursing F	fome 5 ☐ Resid	lence 8 GOthe now injury occurr)
is after death. To Director: After the in by the funeral Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury M	tnjury at Work? 1 Yes 2 No		,,		
octor: After by the fune	3 Suicide 6 Could not be	28e. Place of Injury - At he	ome, farm, street, factory, o			Street and Number	er or Rural	Routa Number,
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Funer Funer tely fil	29a. Certifier (Check only one) 2 Medical Examin	clan: To the best of my knoer: On the basis of exemina and menner stated.	wledge, death occurred at tion and/or investigation, in	the time, date and place my opinion, death occu	e, and due to the curred at the time, o	ceuse(s) and ma dete and place, s	nner as sta and due to	ated. the cause(s)
within 2 To the comple	29b. Signature and title of certifier	and morning stated.	29c. L	icense number		29d. Date signed	(Month, D	Day, Year)
s ⊨ 8	De Mi	al .	n	D2/11-1	1	Bat	27	AMA
	20 Name and addition library	Color Mc	n 22a) (Type Brint)	J /6 7 1	00	wel.	1/1	Just
	30. Name and eddress of person who con	npleted cause of death (Iten	11 0	500 Pennsyl				
CASA	31. Date filed (Month, Day, Year)	32. Registrar's Signs		agerstown,	MD 21/42			
State Registrar	OCT 3 0 200	7		uls				
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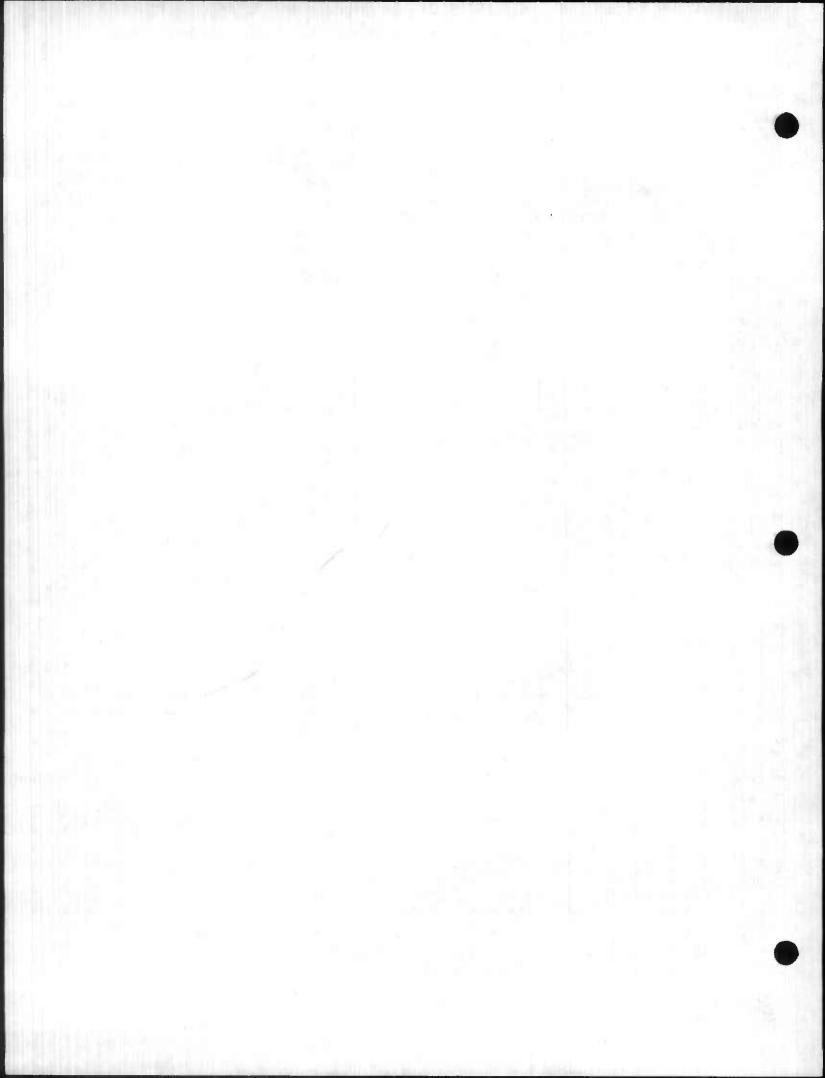


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State of Maryland / Department of Health and Mental Hygiene 00 36457

			Ce	rtificate of	Death		Reg. No.		
Physician /Medical	1. Decedent's Nama (First, Middla, L IRENE ELIZABE					2. Data of D Month Octob	Day	Yaar 2000	3. Tima of Death
Examiner	4a Facility Nama (If not institution, g Washington Cour				Нас	n, or Location of Dea gerstown	Wash	y of Death ingto	n County
Funeral Director	179-09-4320	Sex 7. Aga (In	yrs. last birthday, 85 Yrs.	If Undar 1 Yas Months Day		Min. 8. Data of B	orth (Pear) 13, 1914	9. Birthpi Count Mar	iaca (Stata or Foraig try) yland
death with the Maryland ms 23s or 28s-f show crimits to portified at neral Director	Usual Residence of Decedant 10a. Stata 10b. County MD Washing		c. City, Town or L Hac	ocation gerstown		7.50		10	0d. Inside City Limit
ufer death with the Mei r fems 23s or 28s-f s or the mest be notified Funeral Director	10e. Street and Number 713 Medway Road			10f. Zip Code	21740		10g. Citizan of U.S	What Count	iry?
urs after alt, or Ne Examps by Fui	11. Marital Status 1 Nevar Married 2 Married 3 Xividowed 4 Divorced	12. Was Dacedant Evan Armed Forcas? 1 Yas 2 XNo If Yas, Giva Yaar or Datas:	in U,S. 13.	Was Decedant of If Yas, specify Cu 1 ☐ Yas 2 🗆 N		n? (Specify Yas or N Puarto Ricen, atc.)		ce - Amarice ck, Whita, a y: Whi	atc.
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M out Head	17. Father's Nama (First, Middla, Las J. William Bake	,		3475		s Nama (First, Middle vina Loud			
and 2 should be of the and Mente 27 is marked or traumatic and To E	19a. Informant's Name/Ralationship Leo Patrick Burk					or Aural Aouta Num			
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pemit. Pege Department of Important: If any injury or pace.	21. Signatura of Funaral Service Lice	Finnern		2. Nama and Add Ouglas A 331 East	A. Fiery	Y Funeral	Home gerstown	,Marv	land 2174
Physician /Medical Examiner	23a. Part. Entar the disease or conshock, or heart fillura. Immediata Causa (Final disease or condition resulting in death)	a	- 4	e ave		rollac of raspiratory	arrast,		Approximate Interval Batween Onset and Death
attending physician and from use as the bunklitrensit for use as the bunklitrensit clary. Medical Examiner	Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Diseasa or injury that initiated evants resulting in death) Last	Coron	to (or as a conse	Filey	Herse is cler	ac votré a	ndiel	man	Pan Klise
by the achec	Part II. Other significant conditions	contributing to death but no	ot rasulting in tha	undarlying cousa	givan in Part I.		Yas 2016		the cause of dear
The law requires that also has been signed in page 2 should be del	(2)	Conge Sin	e Hea	ny Fan	lues	24a. Wa	as an autopsy formed?	COS	ere autopsy finding ailable prior to mpletion of causa death?
certificate ha	25. Was case rafarred to medicel	bedily			26. Placa d	of Death (Check only	Yas 2000	10	Yas 2 No
2 00 5	axaminar?	Hospital: Inpatiant	2 ER/Outpatie	ent 3 DOA	Other: 4 Nurs	ing Homa 5 🗆 Ra	sidence 8 🗆 Ot	har (Specify	y)
ath. r: After thise funeral	27. Mannar of Death 1 Divaturai 5 Pending 2 Accident invastigati	28a. Date of Injury (Month, Day Ye	28b. Tima (Injury	N	jury at /ork? □ Yas 2 □ N		e how injury occu	rred	
tal or Attanding P. The death. The din by the funeral certification:	3 Suicida 6 Could not datemine	28a. Place of Injury - building, etc. (S	At homa, farm, s	traat, factory, offic	a	28f. Location City or T	(Straat and Numown, State)	ber or Aura	l Routa Number,
To the Hospital or Attanding P within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Completely filled in by the funeral Medical Certification:	29a. Certifier 1 Certifying F (Check only one) 1 Medical Exa	hysician: To the best of m miner: On the basis of axe and mannar stated.	mination and/or in	th occurred at the nvastigation, in my	tima, data and opinion, death	place, and due to the occurred at the time	e cause(s) and m a, data and place	anner as si , and dua to	sted. tha cause(s)
To the To the Comp	29b. Signatura and title of certifiar	Judelle		29c. Lica	nse number 27898		29d. Date sign	29/0	Day, Year)
	30. Nama and addrass of person who FRANCIS Co La	APORADE	(itam 23a) (Type 350	Print) MILL	ST. 6	Logerst.	on fil	121	740
State	31. Data filed (Month, Day, Year)	32. Begistrar's	Signatura 4	Locak	61	J			- 4 51

DHMH 16 Rsv 6/95



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State of Maryland / Department of Health and Mental Hygiene 36458 Certificate of Death 1. Decedent'a Nama (First, Middla, Last) 2. Data of Death October 26, 2000 **Physician** 3:55 A.M. Helen Nelson Bowman /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Walkersville Frederick Glade Valley Nursing & Rehabilitation Center If Under 24 Hra. Hours Min. If Under 1 Year Months Days 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Data of Birth (Month, Day, Year) **Funeral** 10 M XOF 219-46-9554 84 New York Director June 17, 1916 Usual Rasidence of Decedant 10b. County 10e State 10c. City. Town or Location t0d. tnside City Limits Md. Frederick Frederick 1 ☐ Yes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 5345 Sovereign Place 21703-8381 U.S.A Berns 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Giva Year or Dates: 14. Race - Amarican Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 11. Marital Status 72 hours after 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Fathar's Nema (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Be Pages 1 and 2 should be nent of Health and Mental Helen Hard Charles O. Nelson 19e. tnformant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if of Health a if from 27 is or other trai Mary Ann McCoy (Daughter) 5345 Sovereign Place Frederick, Md. 21703-8381 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata Oct. 27, Burial 2 (Cremation 3 | Remove from State 4 | Donation 5 | Other (Specify) Smithsburg. Md. Smithsburg Crematory 21. Signature of Furieral Service Licens 22. Name and Address of Facility 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 23a. Mrt 1. Entar tha disease, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or haart tailura. List only ona causa on each line. Approximeta tnterval Between Onset and Death **Physician** /Medical immediata Causa (Final diseasa or condition rasulting in deeth) Examiner Obue to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Sequantially list conditions, if any, laeding to immadiata causa. Entar Undarlying Causa (Disaase or injury that initiated events rasulting in death) Last and Due to (or es a consequence of): physician the burial Box 68760 Physician/Medical Dua to (or aa a consequence of): USB signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Ware autopsy tindings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed page 2 20 No 1 Yaa 1 Yas 2 No certificate or Attending Physician: funeral director. 25. Was casa referred to medical axaminer? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To After this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Describe how injury occurred 28b. Time of tnjury 28c. tnjury at Work? Natural 5 Pending invastigation 24 hours after death.

Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be detarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicide 28a. Piace of Injury - At home, farm, street, fectory, office building, atc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edicai completaly (Check only one) within 2 To the 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) iress of pe who completed causa of death (ttem 23a) (Type, Print) M 1475 32. Registrar'a Signature State

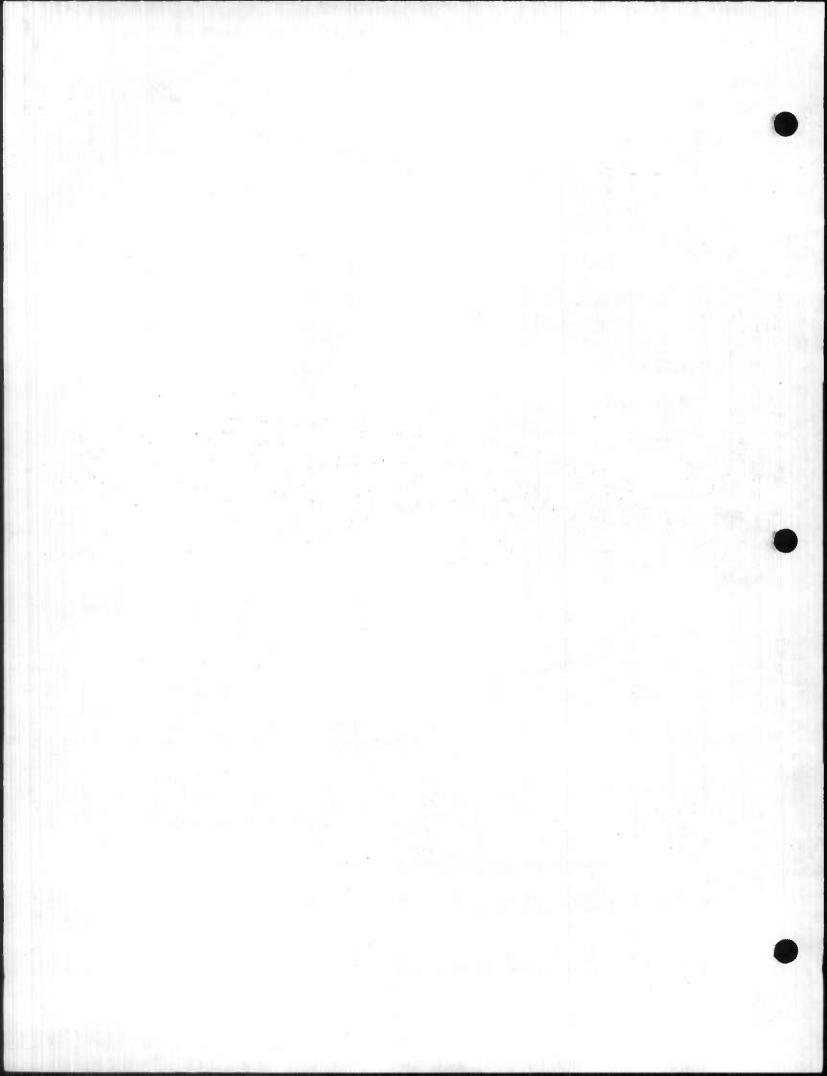
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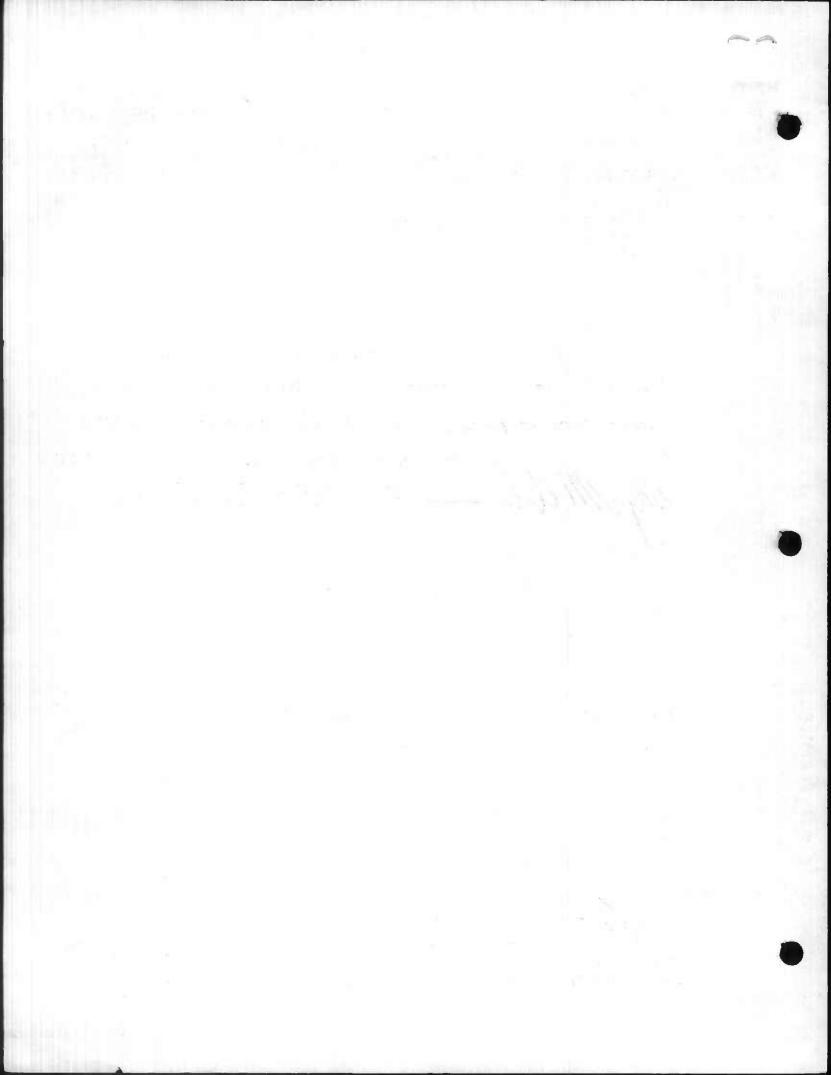
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2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amended State of Maryland / Department of Health and Mental Hygiene Line 4a./WCHD Certificate of Death SC/ 11-1-00 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth **Physician** OCTOBER Effie Eleanor BEARD 12000 /Medical 4a. Fecliity Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner -16000 Salem Ave. Ext. Washington County HospitaHagerstown WASHINGTON 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Deys Hours Min. (Month, Dey, Year) 5. Social Security Number Birthpiece (State or Foreign Country) **Funeral** 1□M 2□F Director 220-10-3094 Aug. 2, 1917 Maryland Usuel Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits r than "natural", or items 23s or 28s-1 show the Medical Examinat must be notified at 1 ☐ Yes 2 ☑ No Director MD Washington Hagerstown 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 16000 Salem Ave. Ext. 21740 permit. Peges 1 end 2 should be filed within 72 hours efter death v
Department of Health and Mental Hygiane.
Important: If item 27 is marked other than "natural", or theme 23a
and Injury or other traumatic event, the Medical Exercises 2008. Funeral USA 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status 14. Reca - American Indien, Bleck. White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify by 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Lic. Practical Nurse Medical 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Martin Perrott Effie Bartles Jacob Naomi 10 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Ivan H. Beard, Jr./Husband 16000 Salem Ave. Ext. Hagerstown, MD 21740 20b. Place of Disposition (Neme of cametery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery Nov. 2, 2000 Hagerstown, MD 21742 22. Name end Address of Fecility OSBORNE FUNERAL HOME P.O.Box # 348 Williamsport, MD 21795 color. or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, heart feilure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Examiner Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): physician a the burial-Physician/Medical Due to (or es e consequenca of): attending pit for use as t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. ed by the detached 23b. Did tobacco use contribute to the cause of death? signed by to 5 be detact 1 Yes 2 No 3 Probably 4 Unknown FIBRILLATION, PORKINSON'S DISBORK SCARD, BLEGANOR by 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Wes en eutopsy Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer?
1 □ res 2 □ No Be 26. Piece of Deeth (Check only one) To Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth Certification: 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Naturel 1 Yes 2 No 2 Accident after deat Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital
within 24 hours a
To the Funeral C
completely filled Certifying Physician: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the cause(s) end menner as steted.

Medical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner steted. 29a. Certifier Medical 29b. Signature and file of certifie 29c. License number 29d. Date signed (Month, Day, Year) D40622 30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print) 19286 MERROWN VION OR HAGERSTONN MO UZI CANIN-MD, 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State Sparks NOV 0 1 2000 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year FRANCIS LEE BENTON October 2000 0/23 27 4c. County of Death 4e. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Deeth Washington County Hospital Hagerstown Washington County If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Feb. 12, 1 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) Months Deys 10XM 2□ F 88 Yrs. 303-34-0754 Ohio Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits MD Washington 1 ☐ Yes 2 No Williamsport 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 16505 Virginia Avenue 21795 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Yes 2 No Specify: White Specify: 3 ☐Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grada complated) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) Professor 12 8 College 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Theresa Sheeran Henry L. Benton 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Elizabeth Bratthauar/Daughter 13002 Lance Circle, Hagerstown, Maryland 21742 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Dafe 20c. Location - City or Town, Stete 1 St Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) New Lexington Cemetery Nov. 6 New Lexington, Ohio 22. Name end Address of Facility
Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses Lun 1331 Eastern Blvd., N., Hagerstown, Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, euch es cardlac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onsef end Death immediate Cause (Final disease or condition resulting in death) Cercbral Hemorrahage 4 days Due to (or as a consequence of):

Physician /Medicai Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

the Maryland

permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is merked other than "natural", or Items 23a or 28a-f show any injury or other traumetic event, the Medical Examinat must be not that

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Examiner ettending physician and for use es the burial-transit

Physician/Medical by Completed Be P

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After this funeral

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I Director: After od in by the funer

within 2 To the F

Hospital 24 hours Certification:

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events thet initieted events resulting in death) Last

Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given In Part I.

Due to (or es a consequence of):

25. Was cese referred to medical examiner? Hospital: 1 ☑Inpatienf 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 20 No 27. Menner of Death 1 Natural

5 Pending investigation

6 Could not be determined

28c. Injury at Work? 1 Yes 2 No 28e. Place of Injury - Af home, ferm, streef, factory, office building, etc. (Specify)

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 1 National Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and manner stated.

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

24a. Was an autopsy performed?

1 Yes 2 No

29b. Signature and title of certifie

29c. License number 45936 29d. Date signed (Month, Day, Year) 16-30-00

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings eveilable prior fo completion of cause of death?

1 ☐ Yes 2 No

30. Name and eddress of person who completed cause of death (from E3a) (Type, Print)

Radle 2000

2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

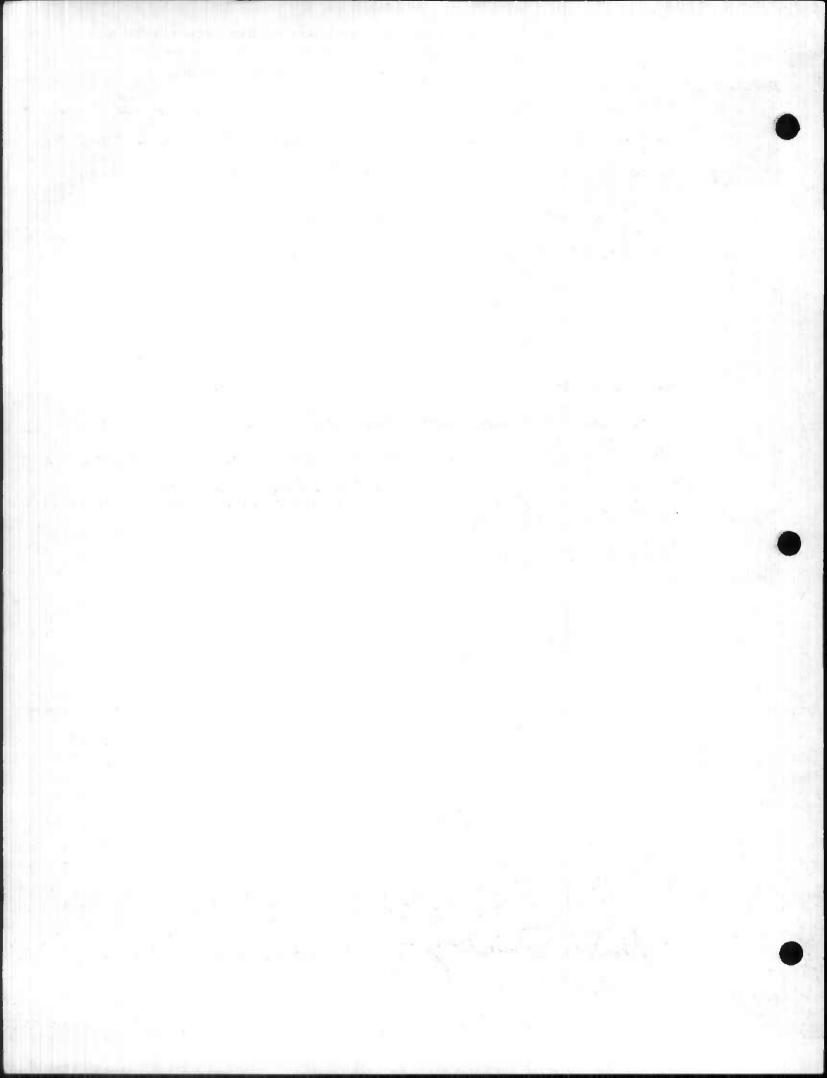
4 | Homicide

medical 11111 32. Registrar's Signeture

Campus Dr Hag. Md. 21742

State Registrar

Medical



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dev Month **Physician** 6:35 P.M. 31 Ruth Elizabeth Biddle 2000 Oct. /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Hagerstown W
If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) Avalon Manor Nursing Home Washington If Under 1 Yeer 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1□ M 2⊠ F 216-22-9979 Director 23, 1926 Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 No Yes 2 No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17 N. Mulberry Street 21740 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ᠫ No If Yes, Give Year or Dates: 14. Rece - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☑ Divorced White Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Buainess/Industry Elementary/Secondery (0-12) College (1-4or 5+) Riogs Hospital

18. Mother's Name (First, Middle, Maiden Sumame) 8 Aid 17. Father's Name (First, Middle, Last) Be Roy Hubert Swope Edna Mae Hovis 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If hem 27 is any injury or other tra 13868 Cresspond Road Clear Spring, Md.21722 Gary L. Shank Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Date 1 ☑ Buriei 2 ☐ Cremetion 3 ☐ Removai from State 4 ☐ Donation 5 ☐ Other (Specify) Beaver Creek Cemetery 11/3/00 Beaver Creek Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 305 N. Potomac Street Gerald N. Minnich Funeral Home Hagerstown, Maryland 21740 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, auch as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset and Death **Physician** Immediate Cause (Final diseese or condition resulting in death) /Medical Acute Myo Cardial Infarction Examiner Athro sclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or es a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown History of shoke P 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Was en autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) of 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Division 1 Watural 5 ☐ Pending death. 1 Yes 2 No 2 Accident n 24 hours after death.

• Funeral Director: A pletely filled in by the f 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Piece of Injury - At home, farm, atreet, factory, office building, etc. (Specify) 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

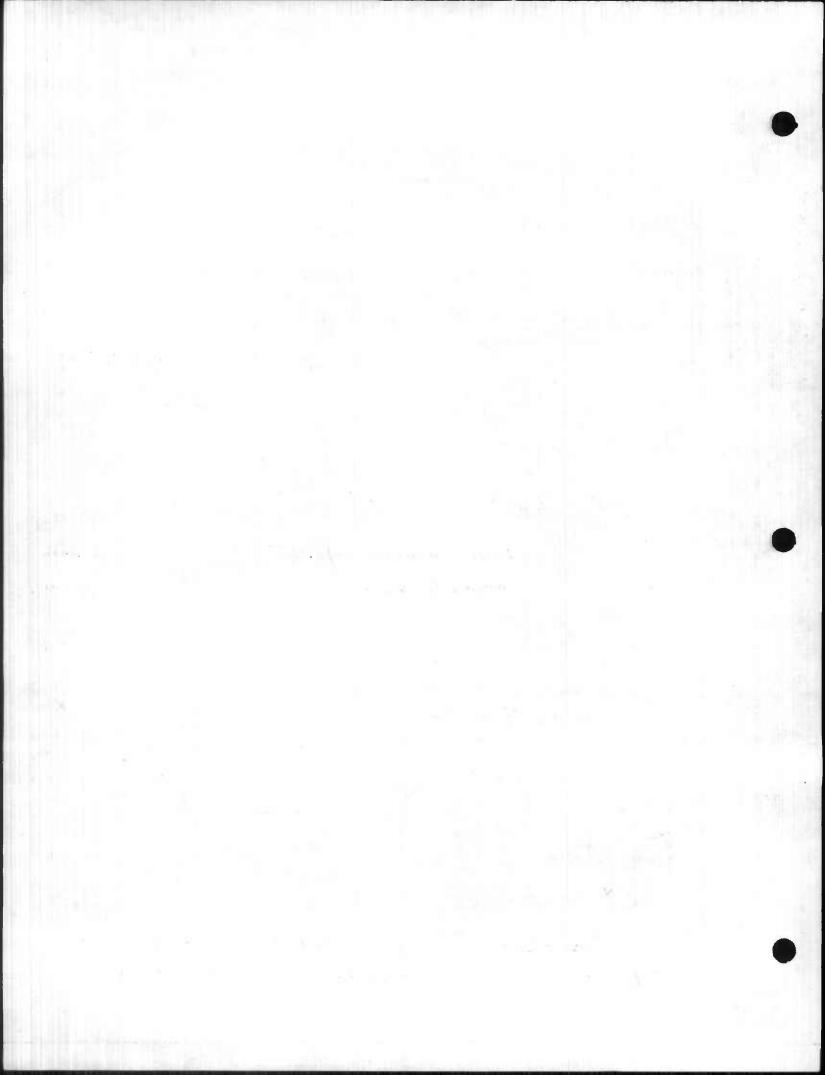
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and title d certifier 29c. License number 29d. Date aigned (Month, Day, Year) D44996 Nov. 2. 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)

Lafar MG/I/L MD 203// Lafipans Rd Boonsboro MD 21713

State Registrar 31. Date filed (Month, Dey, Year)

NOV 0 3 2000

32. Registrar's Signeture

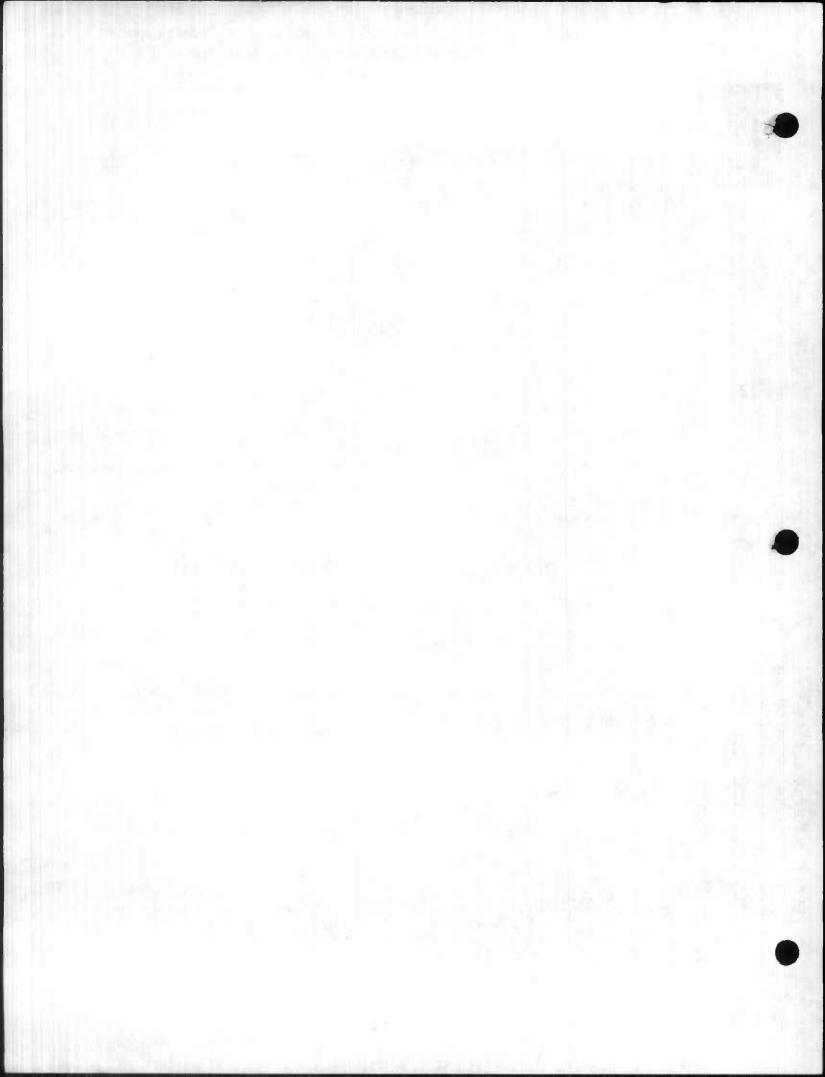


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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					Cert	ificate of	Death		Reg. No.		00406
	1. Decedent's Name	e (First, Middle,	Last)			X.C.		2. Dete of De Month		Van	3. Time of Death
Physician	Ruth A. H	Booker						Octobe	r 22, 20	Yeer 000	2:08 am
/Medical Examiner	4a Facility Name (/	f not Institution,	give street end num	nber)	-		4b. City, Town, or	Location of Death			
Examine	Mariner H	lealth o	f Rethes	10			Roth	esda	Monto	20001	***
Euroval	5. Social Security N			7. Age (In yrs. Ia		If Under 1 Year	r If Under 24 Hrs	s. 8. Date of Birt	Monts		Diace (State or Foreign ntry)
Funeral Director	578-62-14		1□M 2☑F		92 Yrs.	Months Days	s Hours Min	Februa		Cou	So. Carol:
	Usual Residence of					1		reblua	Ly 22, 1	1900	so. Caror
death with the Maryland rms 23a or 28a-f show Linest be notified at neral Director	10a. State	10b. County	1-1	10c. City,	Town or Loca	ition					10d. Inside City Limits
day or	D.C.			T71-4							1 Yes 2 No
28a-f show correct at	10e. Street and Nur	nhar		wasni	ington,	10f. Zip Code			10g. Citizen of V	What Cou	ntn/2
r items 23a or 28a-f shoring and internal second of the Funeral Director						101. Lip 0000			rog. Onizon o. v	, , , d	, .
a 23	5003 13th	Street					20011			J.S.A	
her m	11. Merital Stetus		Armed For		5. 13. W	as Decedent of les, specify Cul	Hispenic Origin? (S ben, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	Blac	k, White,	cen Indien, etc.
2 1	1 Never Merri		d 1 ☐ Yes If Yes, Give	2 ☆ No	10	Yes 20 No	Specify:		Specify		
lby	3 Widowed	4 ☐ Divorced	Year or Da	ites:							ack
event, the Medical Be Completed	(Spec	15. Decedent's	Education grade completed)		16a. Decede	nt's Usual Occu	upation e du <i>ring</i> most of wo red)	orkina	16b. Kind of Bu	siness/In	dustry
3 0	Etementary/Seco		College (1-	4or 5+)	life. DO	NOT use retire	ed)				
4 0			4		School School	Teache	er		Educatio	n	
e de	17. Father's Name	(First, Middle, La	est)	THE STATE			18. Mother's Na	ame (First, Middle,	Meiden Sumem	0)	
To B	James Bak	er					Mittie	McCall			
T I	19a. Informant's Na		(Type Print)		19b. Maiting	Address (Stree	et and Number or F		er. City or Town.	State, Zia	c Code)
important; it tain 27 is marked order than any Injury or other traumatic event, the training once. To Be Comp											
the character of	William H		/Brotner	20h Pie	503 13 ace of Disposit		et; N.W.	Washing	20c. Location -		
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Č5	4 Donation	5 ☐ Other (Spe	city)	Rock	Creek	Cemete	ery	10/30/200	00 Washi	ngto	n: D.C.
- S	21. Signature of Fu	oral Service Li	censee		22.1 Form	Neme end Addr	ress of Facility			0	
any one	> V	wan c	war	. 0			ln Funeransburg R		1 vm	007	0.0
	23a Part Inter It	ne disease or or								207	Approximate
	23e. Part. Enter the shock, or hear	rt failure. List or	nly one cause on ea	ch line.			,			1	Interval Between Onset and Death
ician dical	Immediate Cause (Cinal	TH	-/2	1 6	1	1 1	1		1	
niner	disease or condition resulting in death)		· all	Myron	lote	Con	lionely	- In	ear		slan
-	Todaking in dodkiny			Due to (or	as a conseque	ence of):	,	1			0
in ei			- b							1	
tran	Sequentially list cor	nditions,		Due to (or	as e conseque	ence of):					
ŵ	Sequentially list cor if any, leading to im cause. Enter Unde Cause (Diseese or	rlying									
is the burial-transit	that initiated events resulting in deeth) I		C	Due to (or	as a conseque	ence of):				1	
C1 00 -	resulting in deeting to	Last								1	
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Physician/	Pert il. Other aignif			ath but not resul	iting in the und	enying ceuse g	oven in Part I.				11
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by										245 14	laca autonou fin tir
To Be Completed by	1 non	ente.						24a. Was perfo	an autopsy ormed?	24D. W	fere autopsy findings vailable prior to empletion of ceuse
2 sr	- 100	V. /							L	of	death?
ege C	The second of							10	Yes 20 No	1	☐ Yes 2☐ No
director, page 2	25. Was cese refer	red to medical					26 Place of De	eath (Check only o	nne l		
nect C	axaminer?		Hospital:		D/O 4-4-4	3D DOA	Wher: \/			a. (Cana	16.4
	27. Manner of Death			-	R/Outpatient 28b. Time of			Home 5 ☐ Reside	how injury occur		ny)
fune fune for	1 Netural	5 Pending		f Injury h, Day Year)	Injury	28c. Inj W	ork? □ Yes 2 □ No	200.000.00	.,		
Jin by the	2 ☐ Accident 3 ☐ Suicide	investigate 6 Could no	t he					006 1 6	Canada and About		al Davida Musikas
in by the	4 Homicide	determin	ed Zoe. Flace	of Injury - At hor ig, etc. <i>(Specify)</i>	ne, farm, stree	et, factory, office	θ	City or To	street and ryumb wn, State)	er or Hur	ral Route Number,
pletely filled in by the funera											
cal cal	29e. Certifier (Check only		Physician: To the it								
completely filled Medical Ce	one)	Z MOUICEI EX	and mann		on and/or live	sugation, in my	opinion, death occ	oned at the time,	dete and piece,	and due	to the cause(s)
completely filled Medical Ce	29b. Signature and	titly of certifier	11	. 1 .			nse number		29d. Date signe		
1	> Var	1 1	lula	14.17		11)2	05/6		Oct. P.	2	3. 2000
)	20 14-1	4		and also sale to	00-1 (7	alant)			- Gove	7	7,4
1	30. Name and addre	ess of person wh	no completed ceuse	1 - 1	23a) (Type, P	nint)	RIL R	Thank	ND	200	7/4
	Jel Je	nu/m	0, , , ,			1 mort	1. (1. 1) 6	74116	1/1	- 4	//
State	31. Date filed (Mont			gistrar's Signati	ure	,					
Registrar	OCT	3 0 200	ac.	wa	19.	for de	.4				

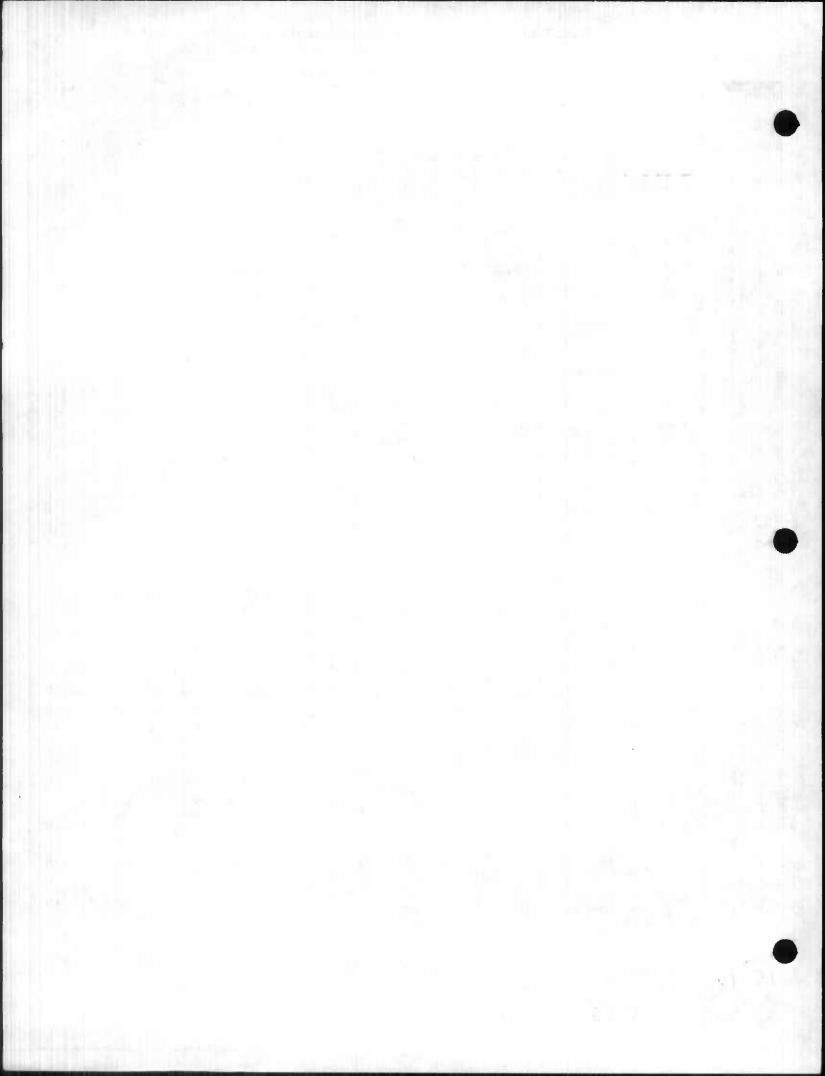
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amend item	5 per fh G789 11/22/00 yf	Certific	cate of Deat		Reg. No.		
Physicia	Decedent's Name (First, Middle, Last)			2. Dat Mo	e of Death nth Day	Yaar	3. Tima of Death
/Medica		own		10	26	2000	9:00 p.m.
Examine	4a Facility Nama (If not institution, give street end number)		4b. City,	Town, or Location	of Death 4c. Co	unty of Death	
	Heartland Health Care Cen	ter Adelphi	Ade	elphi	Pri	nce Ge	orge's
Funeral			Inder 1 Yaar If Und hths Days Hour	dar 24 Hrs. 8. Dat rs Min. (Mo	e of Birth onth, Day, Year)	9. Birth	olaca (State or Foreign
Director	210-03-110950 1MM 20F 8	6 Yrs.	and Days Hodi	Ma	y 2, 1914		yland
2	Usual Residence of Decedent						
how	10a. Stata 10b. County	10c. City, Town or Location				1	10d. Inside City Limits
W P	Maryland Prince George's	College Park					1 X Yas 2 No
with the Ma	10e. Street and Number	10	I. Zip Code		10g. Cifizer	of What Cour	ntry?
h wit	5001 Pierce Avenue		20740		U.	S.A.	
within 72 hours after death with the Maryland ene. than "setural", or thems 23s or 28s-f show the Medical Erain or mart be notified a	11. Marital Status 12. Was Decedent	Evar in U.S. 13. Was C	ecedent of Hispanic specify Cuban, Mexi	Orlgin? (Specify Ya	s or No- 14.	Race - Americ	
P 2 1	1 Nevar Married 2 Married 1 Yas 2 II Yes, Give	No If Yes,				Black, Whita,	
within 72 hours after ene. than "netural", or ite	3 ☐ Widowed 4 ☐ Divorced	WWTT 1 Y	es 2 🛚 No Spec	cify:	Sp	ecity: Bla	ack
2 ho	15. Decedent's Education	16a, Decedent's	Usual Occupation		16b. Kind	of Business/In	dustry
ed within 72 ho ygiene. er than "naturi ft, the Medical	(Specify only highest grade completed)	(Give kind o	of work done during m OT use retired)	nost of working			
with than	Elementary/Secondary (0-12) College (1-4or 5		Service Adm	inictrati	on Fodors	1 Corro	rnmont
filed withi Hygiene. rther than ent, the	17. Fathar's Name (First, Middle, Last)	General		other's Name (First,			Liment
SET A	James Brown				exander		
Men Men Men Men Men Men Men Men Men Men		401 14-77 44				04.4- 70	0-4-1
permit. Peges 1 and 2 shou Department of Heelth end M Important: if Nem 27 is mart any injury or other traumati	19a. Informant's Name/Relationship (Type, Print)		tress (Street end Nur				
and leelt m 27 her 1	Shirley Brown - Niece	5107 U	pshire Str				
A THE	20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Disposition cemetery, cremetor)	or other place)	Date	20c. Locat	ion - City or To	own, State
Peg Int:	4 □ Donetion 5 □ Other (Specify)	MD. Veteran	's Cemete:	ry 11/2/2	2000 Chelt	enham,	Maryland
part.	21. Signature of Funeral Service Licenses		e and Address of Fa				
89E 8		4739	Baltimore	e Avenue,	Hyattsvi	11e, M	20781
	23s. Part . Enter the disease, or complications that caused shock, or heart failure. That only one cause on each life.	Do not enter the	mode of dving, such	as cerdiac or respir	ratory arrest.	1	Approximate
Dhusisian	shock, or heart failure. Litt drily one cause on each	18.					Interval Between Onset and Death
Physician /Medical	Immediate Cause (Final						
Examiner	disaase or condition a. Multi S	System Failure	9				Days
		Due to (or as a consequence	e of):				
pa jis	b. Prolong	g Cardiopulmon	nary Arres	st	360	i	Days
and -tran	Sequentially list conditions,	Due to (or as a consequence	of):				
e ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Cause (Disease or injury	ular Fibrilla	ation				Days
ficate be executed physician end is the burial-transit	that initiated events resulting in death) Last	Due to (or as a consequence				1	
		y Atherosclei	rosis				Years
andir use	d. Colonal	y meneroserer	0010			1	Tears
death certi	Pert II. Other significant conditions contributing to death b	ut not resulting in the underly	ing cause given in Pe	ert I. 23	b. Did tobacco us	e contribute t	o the cause of death?
es that the death certificated by the attending be detached for use a					1 □ Yea 2 🔯		bably 4 Unknown
that det	End Stage Renal Disease, Co	ngestive Hear	t Failure		I I I I I I I I I I I I I I I I I I I	40 0	
requires wen sign hould be				24	a. Was an autopsy	24b. W	ere autopsy findings
been si should	Lower Gastrointestinal Blee	ding, Severe	Anemia,		performed?	CC	valiable prior to empletion of ceuse
8 8 6							death?
The law requir	Anoxic Encephalopathy				1 □ Yas 2 🔯 I	No 1	☐ Yes 2X No
Physician: The rthis certificate and director, page	25. Was cese referred to medical axaminar?		100	lace of Death (Chec	k only one)		
hysic il dire	Hospital:	nt 2 ER/Outpatient 3	DOA Other: 4K	Nursing Homa 5	☐ Residence 6 ☐	Other (Speci	fy)
g Ph er th neral	27. Manner of Death 28a. Date of Inju	y Year) 28b. Time of injury	28c. Injury at Work?	28d. De	scribe how injury o	ccurred	
Attending in deeth.	1 XNaturel 5 Pending (Month, De 2 Accident investigation	M		2 □ No			
Attendi r deeth octor: A by the f	3 Suicida 6 Could not be determined 28e. Place of Inj	ury - At home, ferm, street, fa	actory, office		cation (Street end A	lumber or Run	al Route Number,
tal or Attending P rs after deeth. al Director: After t led in by the funers	4 Homicide building, ef	с. (эреспу)		Cn	y or Town, Stete)		
aplta ours meral	29a. Certifier 1\(\overline{\text{N}}\) Certifying Physician: To the best	of my knowledge, death occu	rred at the time date	and place, and due	to the cause(s) en	d manner as s	stated.
n 24 hou n 24 hou ne Funer pletely fil	(Check only one) 2 Medical Examiner: On the basis of and menner str	examination and/or investig	ation, In my opinion, o	deeth occurred at th	e time, date and pla	ace, and due t	o the cause(s)
To the Hospital or Attending Physician: The I within 24 hours after deeth. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	29b. Signature and title of certifier		29c. Licansa numbi	per	29d. Date s	igned (Month,	Dey, Year)
F ₹ F 8	De Justag no	0					
<u> </u>	a Justing .		D 24720		10/27/	2000	
5)11/2	30. Name and address of person who completed cause of d	eath (Item 23a) (Type, Print)					
11/1	Ravinder Rustagi, M.D., 6	132 Landover	Road, Che	verly. M	20780		
State	31. Date filed (Month, Day, Year) 32. Registr	ar's Signature	_,	, 1111			
Registra	OCT 3 0 2000 Seem	w 4 /					

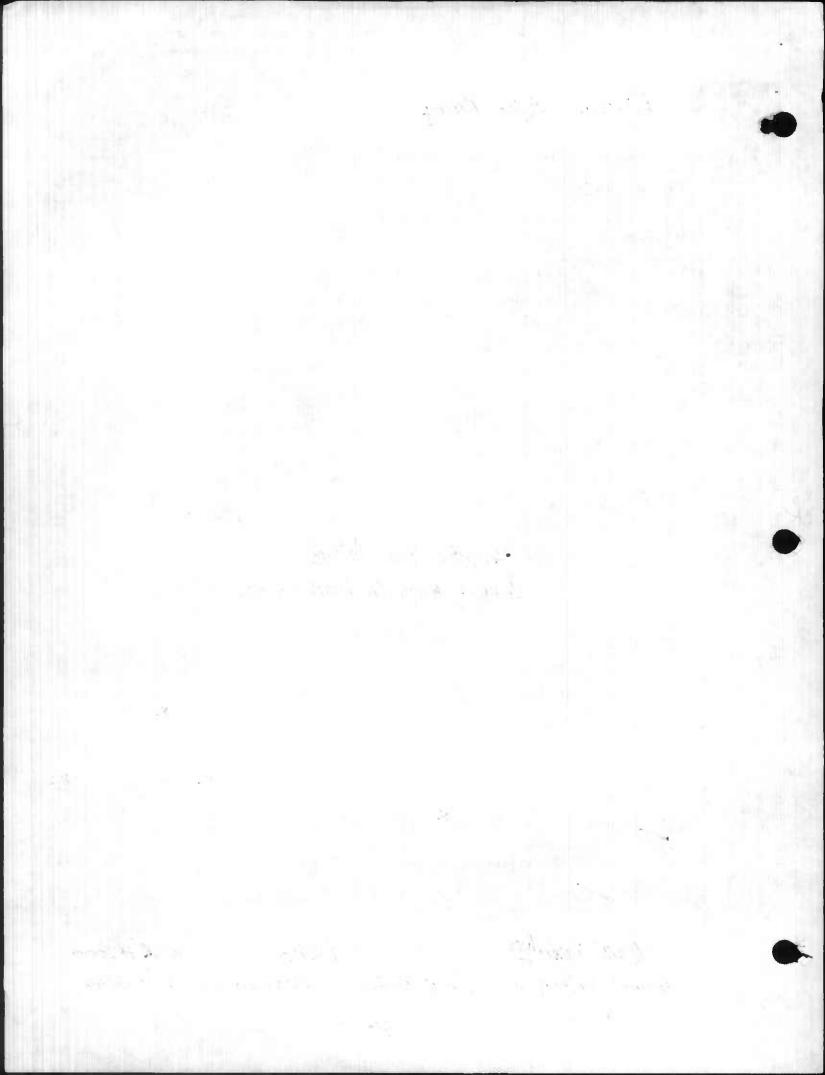
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	1. Decedent's Nama (First, Middle, I	ast) A	1	Certifica	te of De	auı	2. Data of De	Reg. No.	3. Time of De
Physician	Fiatou	Air 1	Barry				Month	Day	Year 7:49
/Medical Examiner	4a Facility Nama (If not institution, g	ive street and number)	4	1	4b. C	ity, Town, or L	ocation of Deat	-	
. Examiner	The Johns	HOPKI'N	s Ho	spital	R	octiv	nore		
Funeral Director	5. Social Security Number 6. Unknown	Sex 7. Ag	e (In yrs. last i	Yrs. Months		Undar 24 Hrs. ours Min.	8. Date of Bir (Month, De 8 - 24 -		9. Birthplace (State or F Country)
Director	Usuat Residence of Decedent			2			0-24-	2000	Maryland
25a-f show notfiled at	10a. State 10b. County Maryland Prin	ce Geo.	10c. City, To	wn or Location					10d. Inside City I
23a-f s notffled rector	10a. Street and Number		Buul		lp Code			10g. Citizan of V	- 1
Liber I	3460 Andrew C	+			724		123	USA	viat oodiniy.
THE 2	11. Marital Status	12. Was Decedent				nic Origin? (Sp	pecify Yes or No Rican, etc.)	_	e - American Indian,
if, or hams comfort my by Funer	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 25 If Yes, Giva Year or Dates:		If Yas, sp 1 ☐ Yes		laxican, Puerto pecify:	Rican, etc.)		Black
ted bet	15. Decedent's	Education	16	a. Decedent's Us	ual Occupation	1	to the Care	16b. Kind of Bu	usiness/Industry
within 72 no ypiere. wr than 'natur it, the Medical. Completed	(Specify only highest g	College (1-4or	5+)	life. DO NOT	rork done dunin use ratired)	g most or won	king		
Con the	0			None				None	
Mental H inked oth affic even	17. Father's Name (First, Middle, La. Salieu Barry						ne (First, Middla a Phal	, <i>Maiden Sum</i> am 1	(0)
Pull	19a. Informant's Name/Relationship	(Type, Print)	1:	9b. Malling Addras	ss (Street and	Number or Ru	ral Route Numb	er, City or Town,	Stata, Zip Coda)
127 tr	Salieu Barry-	Father	3	460 And	drew C	t. #20	01, Lau	rel, Mar	yland 207
of He	20a. Method of Disposition	72	20b. Placa ceme	of Disposition (Natery, crematory or	ame of other place)		Date	20c. Location -	City or Town, State
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shoul lete			9.79				24a. Was perf	s an autopsy omed?	24b. Were autopsy find available prior to completion of cau of daath?
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certificata rector, pag	25. Was case referred to medical					DI (D.	•	¥es 2□No	1 Yas
s certific director,	examinar?	Hospital:		Outpatiant 3 0	Other		th (Check only		or (Conside)
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After th funeral	1 Natural 5 Pending Investigat	(Month, Da	y Year)	Injury M		2 □ No			
7 de de	3 Suicide 6 Could not determine	be 28e. Place of Inj	ury - At homa, c. (Specify)	farm, street, facto	ory, office		28f. Location City or To	(Street and Numb wn, State)	per or Rural Routa Numbe
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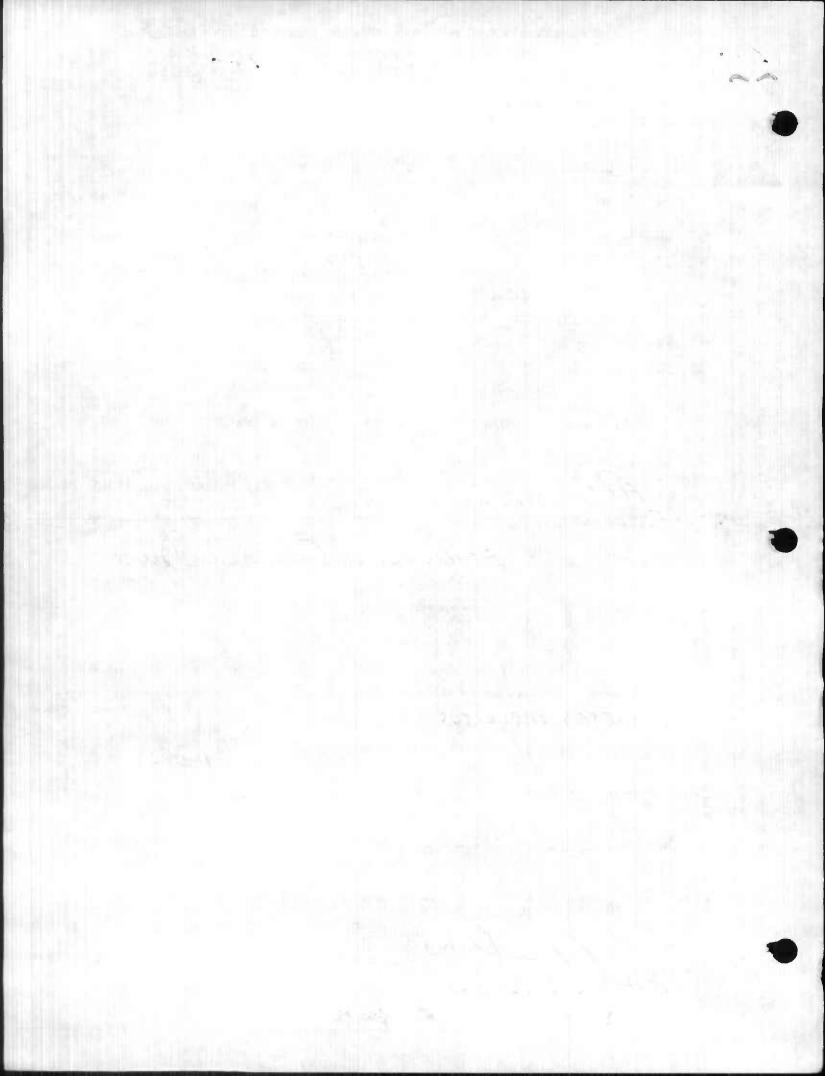
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State of Maryland / Department of Health and Mental Hygiene 00 36465

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/Medical						Ab Cibi To	um arla		-	2000	14:03 PM
Examiner	4a Facility Name (If not institution, git 1116 LUND PLACE	ve street and numbe	91)			KEN	ISING		MC	NTGON	MERY
Funeral Director		Sex 1 2 M 2 □ F	Age (In yrs. last bir 50	Yrs. If Un Monti	der 1 Year hs Days		24 Hrs. Min.	8. Date of Bir (Month, Da 4/27	h y, Year) /50	9. Birthp Coun WASH.	laca (Stete or Foreig try) DC
2	Usual Residence of Decedent 10a. State 10b. County		40a City Tay	n ex l continu	9115						
ahow det			10c. City, Town or Location							0d. Inside City Limits 1 ¥Yes 2 □ No	
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ages 1 ant of H t: If the y or off	20a. Method of Disposition 1 Buriaf 2 XCremation 3 4 Donation 5 Other (Speci		te cemete	f Disposition (in property) PEAKE (or other pl		1	Date .0/27/00	20c. Location BELT	- 1	wn, State
permit. Pa Departmen Important: eny injury	21. Signature of Funeral Service Licensee 22. Name and Address of Facility POPE FUNERAL HOME 11315 LOCKWOOD										
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be executed icies and burist-transit	Immediate Cause (Finel disease or condition resulting in death) a. ATHEROSCLELOTIC CARDIOVASCULM DISEASE Due to (or as a consequence of): b. Due to (or as a consequence of): if any, feeding to immediate cause. Enter Underlying Cause (Disease or injury cause (Disease or injury cause).										
ing phys e as the	that initiated events resulting in death) Last Due to (or as e consequence of): d										
by the	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. DIABETES MELLITUS						23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably *** Unknown				
s been s 2 should pleted	- DJI) BJE I I B TILLED (10)							24a. Was	an autopsy pred? ARTIAL	av	ere autopsy findings allable prior to mpletion of cause death?
The le page page								108	Ŷes 2□No	10	¥es 2□ No
yelclen: The scentificate director, page Co	25. Was case referred to medical axaminer?			To III.			e of Deat	h (Check only o	one)		
2 00 7	1∆ Yes 2 No	Hospital: 1 Inpe			3 DOA Other: 4 Nursing Home 5 Reside) SCENE
ng the ng	27. Menner of Death 1 Neturel 5 ☐ Pending 2 ☐ Accident investigetic		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No					28d. Describe how Injury occurred			
Partie Ta	3 Suicide 4 Homicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number of Edity or Town, State)									I Route Number,	
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the it Medical Certificati	29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end placa, and due to the cause(s) and menner as stated. 27e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end placa, and due to the cause(s) and menner as stated. 27e. Certifier (Check only one)										
withir To the	29b. Signature and title of certifier	1			29c. Licer	nse number			29d. Date signed (Month, Day, Year)		
	M.D. O.C.M.E.					•	OCTOBER 24, 2000				
(10)	30. Name and address of Jerson who	CIPPLE			n Str	reet,	Balt:	imore,	Marylan	d 212	01
State	31. Dete filed (Month, Day, Year)		strer's Signeture	la	en Ma	'	173				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 6:55AM Doris Boyd 30, 2000 October 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 17, 1915 9. Birthplace (State or Foreign County) Maryland 7. Age (In yrs. last birthday) Days Months Hours 1 M 2 SpF 578-34-9566 Yre Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Suitland 1 Yes ZNO Maryland Prince George's 10e Street and Number 10f Zin Code 10g Citizen of What Country? 20746 U.S.A. 4206 Skyline Drive 14. Race - Americen Indian, Bieck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No 1 Never Married 2 Married White 1 Yes 2 No Specify: 3 ◯ Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Montgomery Wards Elementary/Secondery (0-12) College (1-4or 5+) Sales Clerk Department Store 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Burris Mabel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19304 Muncaster Road Derwood Maryland 20855 Preston Lee King (Grandson) 20b. Place of Disposition (Name of cametery, crematory or other place) Nov. 6, 2000 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burlal 2 □ Cremation 3 □ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Maryland State Veterans Cemetery Cheltenham, Maryland 22. Name and Address of Fecility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD20735 Part 1. Enfor the disease, of complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Adeni Hed Immediate Cause (Final disease or condition resulting in death) Acute myocardial infarction 174 00/00/00 Due to (or as a consequence of): 'oronary Artom Due to (or as a consequence of): 9-1. 10/30/00 Due to (or es e consequence of): AT 0655 HRS Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? Recent total Colecton 1 Yss 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to 24a. Was an autopsy performed? Non i woulin Dependant Diabets Malliks completio of death? N/A

Physician /Medical Examiner

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Completed

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Certification: To

Medicai

Physician

/Medical

Examiner

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7 is marked other than "natural", or itema 23a or 28a-1 show treumatic event, the Medical Examiner must be notified at

al Hygiene.

h and Mental

permit. Pages 1 end 2 : Department of Heelth ar Important: If hem 27 is any Injury or other treu once.

Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Paroxysmal Atrial fibrillation

1 Yes 2 No 1 ☐ Yes 2 ☐ No

25. Was cese referred to medicel examiner? 1 Yes 2 No

27. Manner of Death

1 Matural

29a. Certifier

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work?

26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

10. St. Patricks Drive, waldorf MJ20603.

28d. Describe how injury occurred

5 Pending investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State) 15 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 035295

1 Yes 2 No

29d. Date signed (Month, Day, Year) 10/30 00

Registrar

To the Hospital within 24 hours a To the Funeral D

31. Date filed (Month, Day, Year)

NOV 0 1 2000

32. Registrar's Signature

Junain

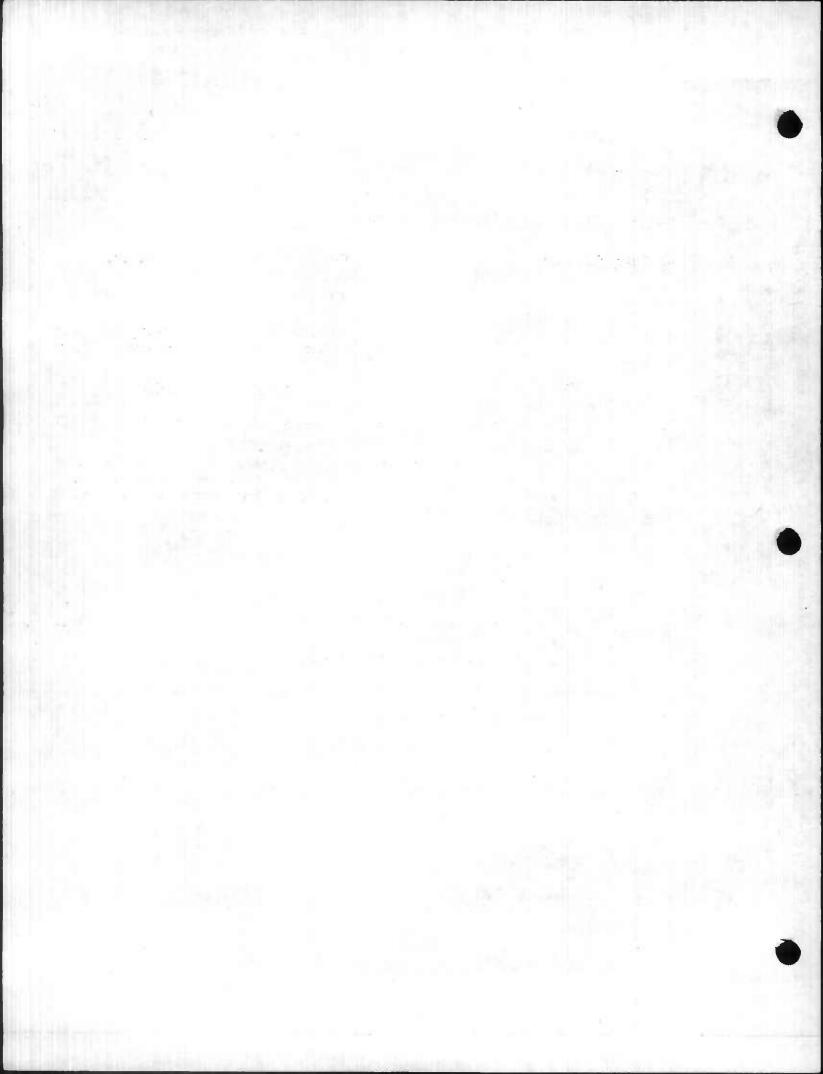
30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

SATISH JUMANI, M.D. 10.8t-Rat

Sports

DHMH 16 Rev 6/95

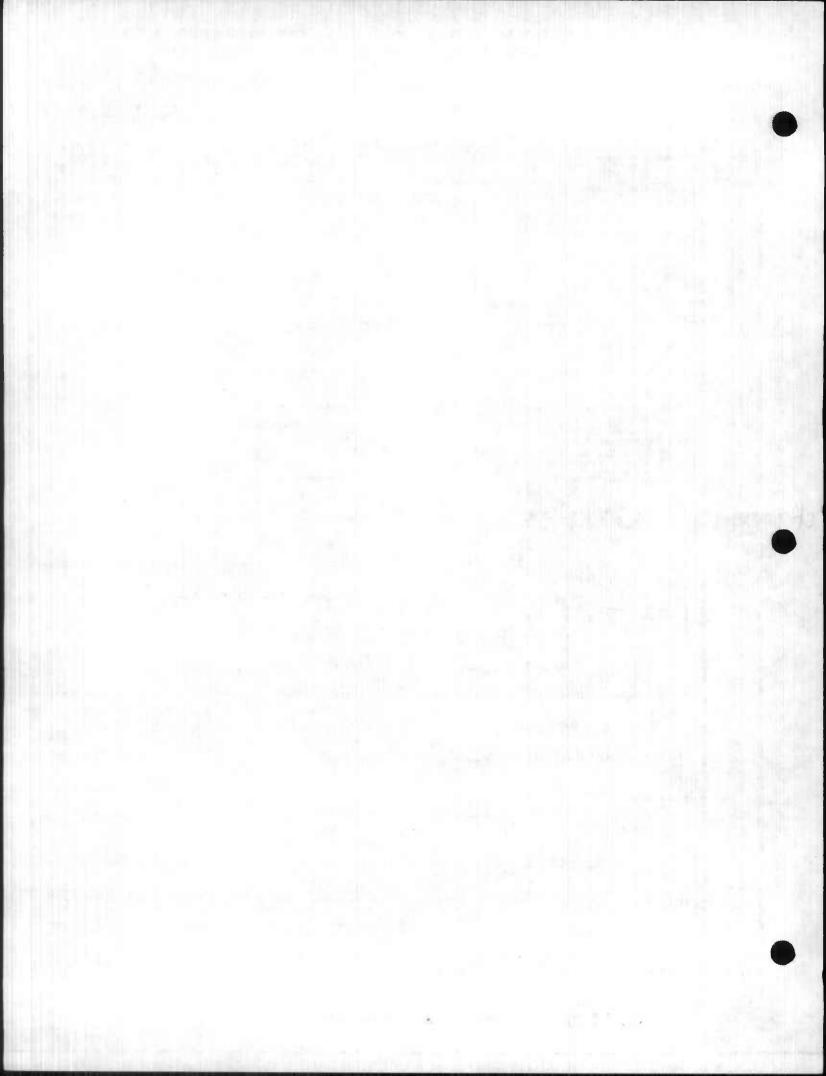
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State of Maryland / Department of Health and Mental Hygiene 0 0 36467

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Year **Physician** Gloria Jean Baskins 11 01 2000 1:00 PM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Doctor's Hospital If Under 1 Yeer | If Under 24 Hrs. 5. Social Sacurity Number 8. Dete of Birth (Month, Day, Year) Birthplace (Stata or Foraign Country) 7. Aga (in yrs. last birthday) **Funeral** Months Deys Hours 1 M 2 F 248-27-3157 Yrs. Director 34 06-24-1966 South Carolina Usual Rasidance of Decedant with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show d 2 should be filed within 72 hours after death with the Maryla th and Mental Hygiene. ? Is marked other than "natural", or itema 23a or 28a-1 show traumate avant, for adding Earth or mast a notified Yes 2 No Funeral Director MD Prince George's Hyattsville 10g. Citizan of What Country? 10f. Zip Coda 10e. Street and Number 5800 Peabody St. 20783 #9 U.S.A. 13. Was Decedant of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarlo Rican, atc.) 14. Rece - American Indian, Black, Whita, atc. 12. Wes Decedant Evar in U,S. Armed Forcas? 11. Merital Stetus 1 Nevar Married 2 Merried 1 ☐ Yas 2 ☐ No If Yas, Giva Specify: Black Maryland 21215-0020 1 Yas 2 No Specify. Completed by 3 Widowed 4 Divorced Yaar or Datas 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Collega (1-4or 5+) Elementary/Secondary (0-12) Private Collection Clerk 17. Fathar's Nama (First, Middle, Last) 18 Mother's Nama (First, Middle, Meiden Surnama) Leroy Baskins Jennie Ellison 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Neme/Raletionship (Type, Print) permit Pages 1 and 2: Department of Health ar Important: if them 27 is any injury or other trau-ones. 5800 Peabody St. #9 Hyattsville, MD Shashana Baskins Daughter 20783 Baltimore, 20s. Method of Disposition 20b. Plece of Disposition (Nema of cematary, cramatory or other plece) 20c. Location - City or Town, Stata 18 Burial 2 Denimation 3 DRemoval from State Chesterfield County 11-8-00Cheraw, South Carolina 4 Donasion 5 Other (Specify) Fisher Hill Cemetery 21. Signature of Funeral Service Croensee 22. Neme end Addrass of Facility J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, MD Part Inter the disaasa, or complications that ceused the deeth. Do not antar tha mode of dying, such as cardiac or respiratory errast, short, or heart failure. List only and cause on sech line. Approximata Interval Batween Onset and Deeth **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical Sepsis- Respiratory Failure 10 Days Examiner Dua to (or as a consequence of) Physician/Medical Examiner 5 Years Diabetes use as the burial-transit Sequentially list conditions, if any, laading to immadiata cause. Entar Undarlying Couse (Disease or injury that initiated events rasulting in death) Last and Dua to (or as a consequança of) The law requires that the death certificate be execu Years the attending physician Sarcoid Dua to (or as a consequence of): 1 Week Pancreatitis ate hes been signed by the atte-page 2 should be detached for 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Ware autopsy findings available prior to completion of cause of death? 24e. Wes en autopsy performed? Completed 1 ☐ Yas 2 No 1 Yas 2 No or Attending Physician: after death. Be 25. Was casa rafarred to medical 26. Placa of Death (Check only one) Hospifel: 1 ⅓ Inpatiant 2 ☐ ER/Outpalient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 8 Othar (Specify) 1 Yas 2 No Medical Certification: To 28c. Injury at Work? 27. Menner of Deeth 28b. Tima of 28d. Dascribe how injury occurred 1 Natural 5 Panding 1 Yas 2 No invastigation 2 Accident Director: / 6 Could not be 3 Suicide 281. Location (Street and Number or Rurel Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, straet, factory, offica building, atc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and placa, and due to the ceuse(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or invastigetion, in my opinion, deeth occurred at the tima, data and place, end due to the causa(s) and mannar stated. 29a. Certifier 29ç. Licensa number 29d. Date signed (Mopth, Day, Year) 29b. Signatura and title of certifi 10 30. Nema and address of person who completed causa of death (Item 23a) (Type, Print)

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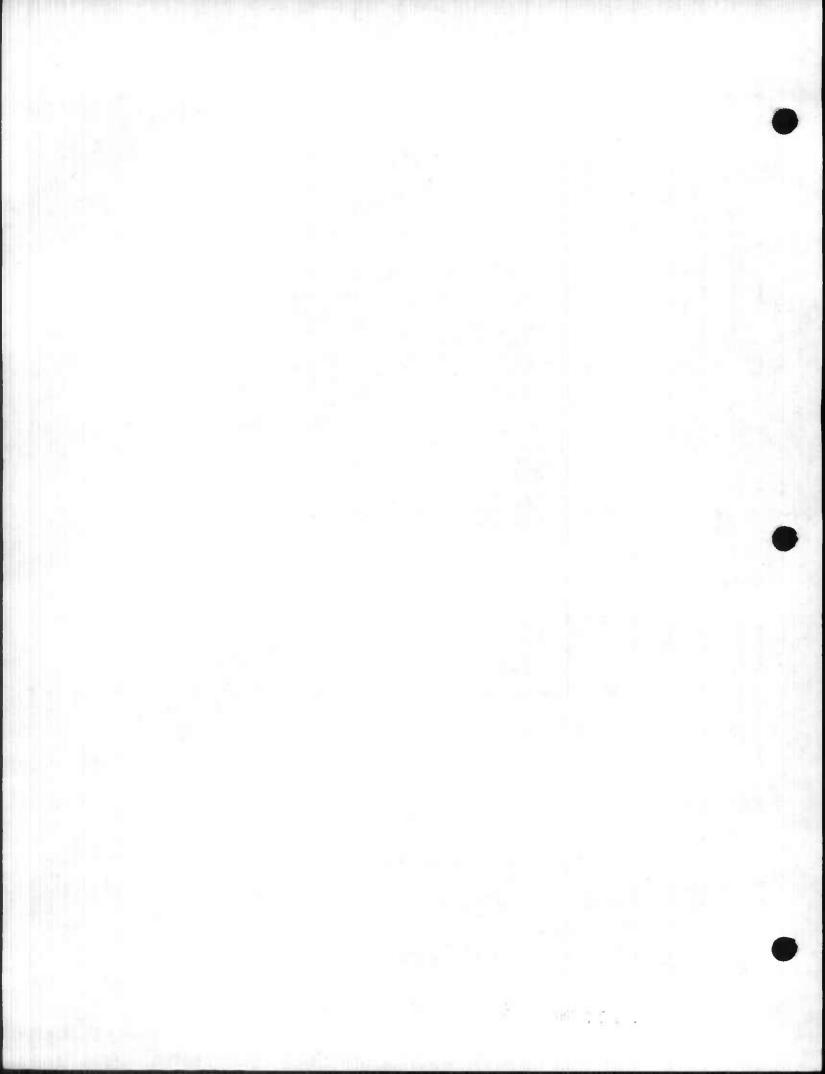
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Box 68760 Division of Vital Records. P.O.



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State of Maryland / Department of Health and Mental Hygiene 0 0 3 6 4 6 9

				C	ertificate	e of Dea	th		Reg. No.		
		1. Decedent's Name (First, Middle, Las	st)					2. Data of Dec	ath	.,	3. Time of Death
	Physician	Henrietta Bl	oomer					Month October	28,200	Year	11:15AM
	/Medical Examiner	4a Facility Name (If not institution, give				4b. City	, Town, or Lo	ocation of Death			11013221
	LAdillillei	Mariner Health of	North Amind	2]		Glen	Burni	6	Anne	Arund	le1
	Funeral	5. Social Security Number 6. S	ex 7. Age (Ir	yrs. last birthda	y) If Undar 1	1 Yaar If Ur	ndar 24 Hrs.				place (State or Foreign
	Director	212-32-6519 Usual Rasidence of Decedent	OM 2 0 F	95 Yrs.	Months	Days Hou	urs Min.	July 8,		Penn	sylvania
	Aaryland Tahow	10a. State 10b. County	ALCOHOLD IN	c. City, Town or						1	0d. Inside City Limits 1 Yes 2 No
	vith the Me or 28s-f a be notified	Maryland Anne Aru	naeı	Glen Bu	10f. Zip (Code			10g. Citizen of V	What Coun	itry?
	23a or				21	061			United :	State	es
215-0020	172 hours after death with the Maryland *naturel*, or items 23s or 28s-f show dical Exercise fruit be notified at leted by Funeral Director	3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Evan Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	in U,S. 1:	3. Was Decede If Yas, specif			ecify Yes or No- Rican, atc.)		e Americ ck, White, Blac	
2-0	72 ho	15. Decedent's Ed	ucation	16a. De	cedent's Usual	Occupation	most of work	ina	16b. Kind of Bu	usiness/Ind	dustry
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Z	and 2 saith ar n 27 is ner trau	Stephanie M. Savag									
6	f Health item 27 other tr	20a. Method of Disposition		Ob. Place of Dis	position (Nam	e of	GICII L	Dete	20c. Location -		
Baltimore	Pege nent o ant: If ury or	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State			remato					Virginia
Bal	pemit. Peg Department Important: I any injury o	21. Signature of Funeral Service Licen	m. Ba	Levo.	22. Name and	Address of F	louces	n M. Ta	ylor Fu	neral lis.	Home, Inc. MD 21401
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the	*					_		Approximate
5	Physician	snock, or near failure. List only	one cause on each line.	,	11	_	-	/		t	Interval Between Onset and Death
4	/Medical Examiner	Immediate Cause (Final disease or condition	· (mees	twe	Hec	N	19	·lunt		1	24Pars
	_	resulting in death)	Due	to (or as a cons	sequence of):	1	0.	0 == 0			11/200
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-6	ificate be associted graystolan and as the burletransit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due	to (or as a cons	sequance of):					-	
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	5 04	resulting in death) Last	d	10 (0) 45 4 50115	equence ory.						8-15-5
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State of Maryland / Department of Health and Mental Hygiene 00 36470

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	Physici		Ruby Emmager	ne Bland						October 31, 2000			5:30AM		
	/Medi Examir		4a Facility Name (If not institution		•)			4b. City, To	wn, or Location		4c. County		J. JOIN1		
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	led led														
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical	(Check only /2 Medical E	Physician: To the besit Examiner: On the basis	of my knowledge, of exemination and/	deeth occurred	et the ti	me, date an	d piece, and du	e to the che time, d	euse(s) end me	nner as s	tated. the cause(s)		
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9			Olymn	W Hall	M)		D4	1216			cet.	31	2000		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month **Physician** Eleanor Ann Berger October 31, 2000 6:12 pm /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner Future-Care Chesapeake Arnold Anne Arundel If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□ M 2□ F Months Yrs. 3/30/1913 105-10-1306 87 Director New York Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Directo Severna Park Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 43 West Mckinsey Road 21146 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ᡚ No If Yes, Give Yeer or Detes: 14. Race - American Indien, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White by 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic event, the little page. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Assistant Proffesor Education 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Emil Schilling Schilling Anna Goepfert 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Theodore J. Berger (son) 550 Herons Nest Annapolis, MD 21401 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition t'E Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Cemetery 11/4/00 Davidsonville, MD 21. Signature of Funeral S 22. Name and Address of Facility John M. Taylor Funeral Home 23e. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, above, or heart failure. Light may one cause on each line.

147 Duke of Cloucester St. Annapolis, MD 21401
Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel diseese or condition resulting in deeth) Examiner Examiner physician end the burial-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Box 68760. erebro vasc Physician/Medical P.O. | Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tohecco use contribute to the cause of death? 1 ☐ Yes 2DXNo 3 Probably 4 Unknown signed t Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) 1 ☐ Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 1 Netural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred Certification: or Attending 5 Pending investigation death. n 24 hours after death.

Ne Funeral Director: A pletely filled in by the fu 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I within 2 To the I complet 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11-1-00 Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 1 Severna Park 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

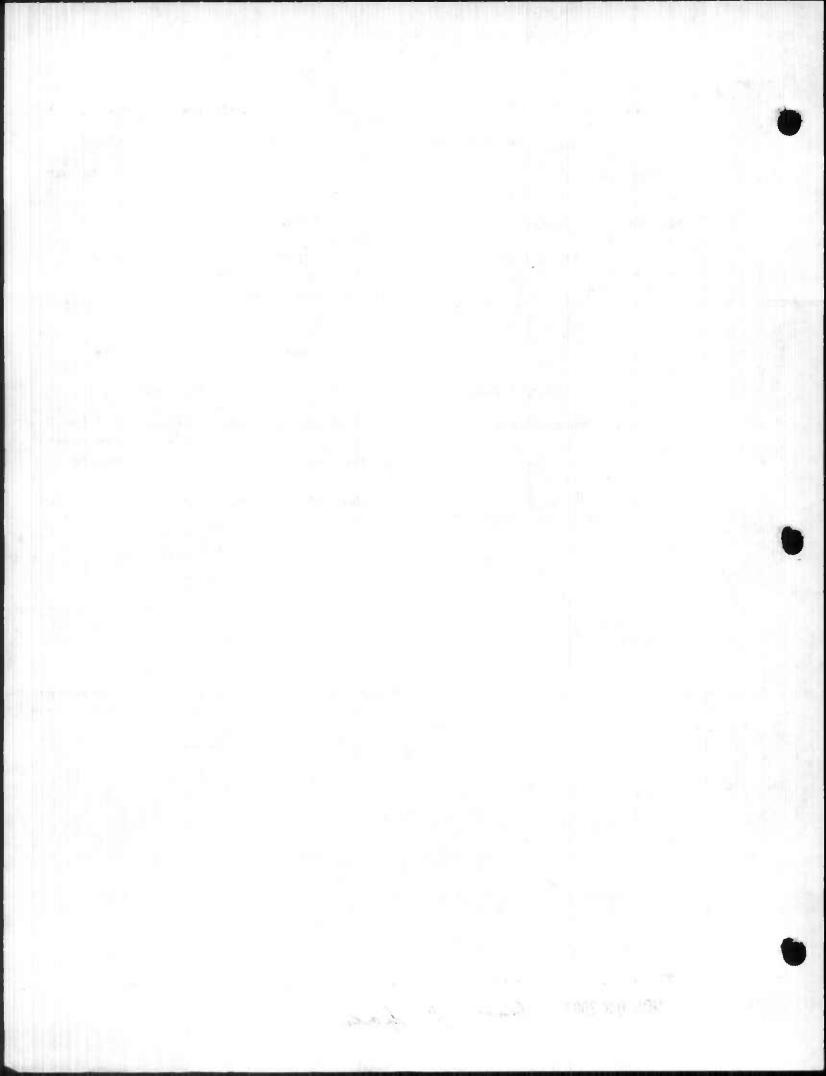
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State of Maryland / Department of Health and Mental Hygiene 0 36472

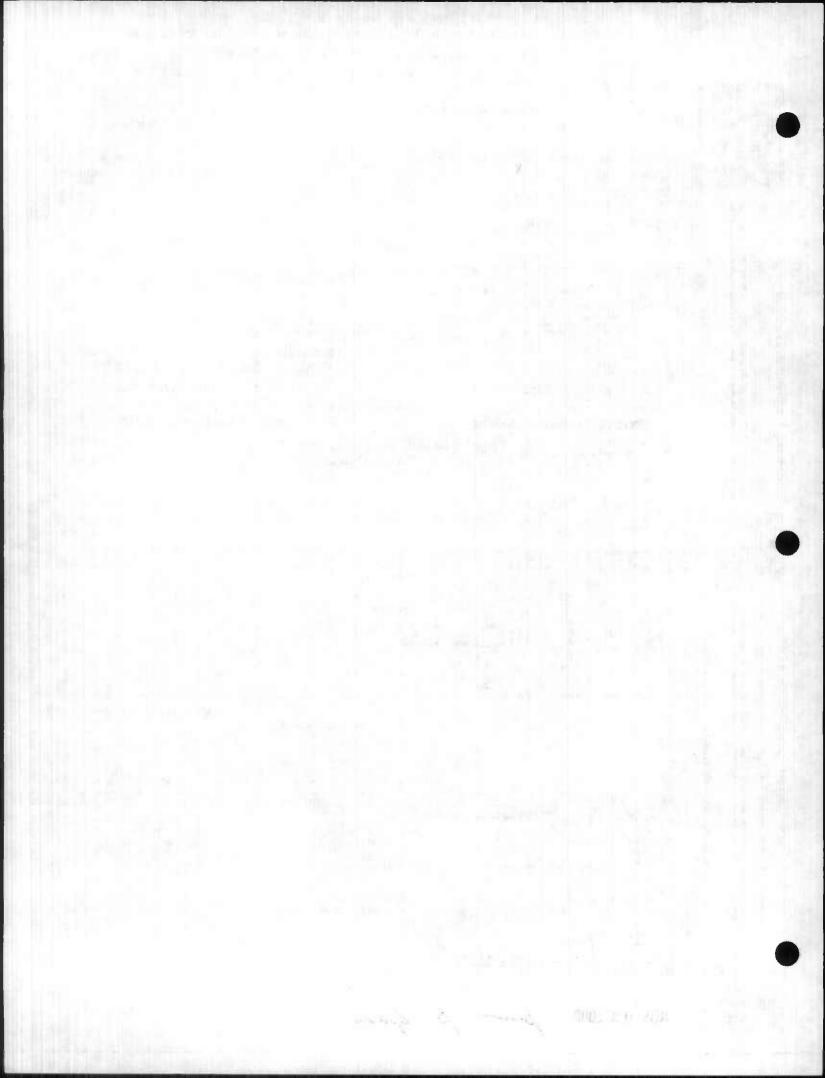
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23b. Did dosect use contribute to 1 Yes 2 No 3 Protection				
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5 to 6 21 Accident investigation will test 2 140	Route Number,			
28a. Piace of Injury - At home, farm, streat, factory, office 28f. Location (Streat and Number or Rura City or Town, State) 29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, end due to the ceuse(s) and manner as st and menner stated. 29b. Signature and title of certifiar 29d. Date signed (Month, I	ted. he ceuse(s)			
29b. Signature and title of certifiar 29c. License number 29d. Date signed (Month, I	ay, Year)			
11 Dans D21244 11/1/00	21244 11/1/20			
30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Tesus H. Tan Frostburg Plaza Frostburg Md. 21532 31. Dete flied (Month Day Year) 32. Registrar's Signature				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 36473

				Certif	icate of	Death		Reg. No.					
Discontatas:	1. Decedent'a Name (First, Middle	Last)					2. Date of De Month	eeth Day	Year 3	. Time of Death			
Physician /Medical		Miriam M	elissa Bec	eman			Novemb		000	10:13 A			
Examiner	4a Facility Name (If not institution,	give street and number)			4b. City, Town,	or Location of Dee			10.12 W			
ZAGIIII	Memorial Hospital & Medical Center Cumberland Allegany												
uneral						rs. 8. Date of Bi	rth Vand	9. Birthplece	(State or Foreign				
irector	218-30-0181	1□M 2MF	65	Yrs.	lonths Days	Hours M	March	21, 1935	Country	(State or Foreig laryland			
	Usuel Residence of Decedent												
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ther must be notified at Funeral Director	Maryland	Garrett	THE R			Lonaconi	ng			1 ☐ Yes 2 No			
Director	10a. Streef and Number				10f. Zip Code			10g. Citizen of 1	What Country?				
0	170	Swamp Road				21539		USA					
Funeral	11. Marital Status	12. Was Decedent	t Ever in II S	13 Was	Decedent of H		(Specify Yes or N	e - American f	Indian.				
5	1 Never Married 2 Marrie	Armed Forces	3	If Ye	es, specify Cub	an, Mexican, Pu	ierto Ricen, etc.)	ck, White, etc.					
by	3 □ Widowed 4 □ Divorced	If Yes, Give Year or Detes:	•	10	Yes 20 No	Specify: White							
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Be	17. Father's Name (First, Middle, L		Millon			16. Mother's I		s, Maidan Sumama) Isie Dora Barnes					
2		Archabald Mac											
	19a. Informant's Name/Ralationsh			9b. Mailing A			Rural Route Numb			de)			
	Albertus Leroy	Beeman-Husbar				90 Swamp	Road, Lona	coning,Ma.	21539				
	20a. Method of Disposition		0.000	of Disposition	on (Name of ory or other pla	ce)	Dete November	20c. Location	City or Town,	Stata			
	1. Burial 2 Cremetion 4 Donetlon 5 Other (Sp	9	Beeman Cemetery 04, 2000						Lonaconing, Md.				
	21. Signature of Funaral Service Licensee 22. Name and Address of Fecility												
1	DA CM	1.01 :			TTI - I. I	M-Vio	Europal II am	DA Ion	occaning N	Ad 21520			
	Eichhorn-McKenzie Funeral Home P.A. Lonaco												
100	the first the disease, or complications that caused the death. Do not enter the mode or dying, such as cerdiac or respiratory arrest, and k, or heart failure. List only one cause on each line.												
n 📗									, Or	iset and Death			
	Immediate Ceuse (Final disaesa or condition	a. Myocard	dial in	farcti	on					4 days			
	rasulting in deeth)		Due to (or as										
ine		Oat Ce	11 Canc	er of	Lungs					3 years			
Examiner	Sequentially list conditions,	0.	Due to (or as	a consequar	nce of):								
Ca	that initiated events resulting in death) Last	c. Tobacci	Due fo (or as	e consequen	ice of):				1				
Medical	1030king in douin/ East												
Cla	Part II. Other algorificant condition	s contributing to death I	but not resulting	o in the unde	riving cause on	en in Part i	23b. Dio	tobacco use co	ntribute to the	e cause of death			
Physician	Part II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.									ly 4 □ Unknow			
Α >								(100 2010	0_1.10	., 4000			
d by							24e. Wa	s en autopsy	24b. Were	eutopsy findings			
ete	E La Constantina de Constantina de la Constantina del Constantina de la Constantina de la Constantina de la Constantina de la Constantina de la Constantina de la Constantina de la Constantina de la Constantina de la Constantina de la Constantina de la Constantina de la Constantina de la Constantina de la Constantina de la Constantina de la Constantina de la Constantina		7.650				per	ormed?	aveilal	ble prior to letion of cause			
du									of dea	th?			
Completed	ELIN TO ROLL BY						10	Yes 2 No	1 🗆 Y	as 2 No			
Be	25. Was casa rafarred to madicel axaminar?						Daath (Check only	ona)					
2	1 ☐ Yes 2 No	Hospital:	ient 2 ER/	Outpatient (3 DOA Oth	ner: 4 Nursin	g Home 5 ☐ Res	idence 6 Ott	nar (Specify)				
	27. Manner of Death 1 Natural 5 Panding	28a. Dete of Inj (Month, D	ury 28t	b. Time of fnjury	28c. Inju	rk?	28d. Dascribe	how injury occur	red				
atic	2 Accidant Investige					Yes 2 □ No							
1	3 Suicide 6 Could no	286. Place of in	njury - At homa	, farm, street,	, factory, office		28f. Location	(Street and Num.	ber or Rural Ri	oute Number,			
Certification:	4 U Horricide	bullaing, e	itc. (Specify)				City of Te	JWII, SIAIE/					
	29a. Certifiar 1 Certifying	Physician: To the best	of my knowled	dga, daeth oc	curred at the ti	ma, data and pl	ace, end dua to the	cause(s) and m	enner as state	nd.			
edicai	(Check only 2 Medicaf E	xaminer: On the basis of and manner s	of examination	and/or invest	tigation, in my o	ppinion, death o	ccurred at the lime	, data and place,	end due fo the	e ceuse(s)			
Z e	29b. Signature and title of certifier				29c. Licens	e number		29d. Date signe	d (Month, Day	v, Year)			
	1												
,	Ja	- M			D549	84		Novembe	r 2,	2000			
	30. Name and address of person who completed causa of death (Item 23a) (Type, Print)												
۵	Dr. Eric Harman 51 Main Street Westernport, MD 21562												
State	31. Date filed (Month, Day, Year)	32. Regist	trer's Signature	1	,								
jistrar	NOV 0 3 2000	Benefic	B	100	uks								

DHMH 16 Rev 6/95



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2 Date	of Dooth	3 Time of
Certificate of Death	Reg. No.	00771
State of Maryland / Department of Health and Menta	l Hygiene	36474

				Certificate	of Death		Reg. No.	00474			
_	1. Decedent'a Name (First, Middle, La	st)	112			2. Date of De Month	ath Day	3. Time of	Death		
sician edical	MARIA E. BORGES					OCTOB		000 6:0	5 AM		
	la Facility Name (If not institution, giv	e street and number)			4b. City, Town, or	Location of Death	ation of Death 4c. County of Death				
	HOLY CROSS HOSP	ITAL				SPRING	GOMERY				
tor	216-80-4784	Sex I□M 2X F	ge (In yrs. last bir 90	thday) If Under 1 Months	Year If Under 24 Hrs Days Hours Min	(Month, Da	th y, Year) 7, 1910	9. Birthplace (State of Country) CUBA	or Foreign		
-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location			10d. Inside C	ity Limits			
ŏ	MARYLAND MONTG	OMERV	BETHE	SDA AGS				1 ☐ Yes	2 No		
Director	10e. Street and Number	OHERI	DETHE	10f. Zip C	ode		10g. Citizen of V	Vhat Country?			
	4521 EAST WEST	HGWY, #707									
Funeral	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Armed Forces	Ever in U,S.			f Hispanic Origin? (Specify Yes or Nouban, Mexican, Puerto Rican, etc.)		e - American Indian, k, White, etc.			
by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		iX Yes 2	□ No Specify:	o Specify: CUBAN		HISPANIC			
ted	15. Decedent's E	ducation	16a. Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use refired)			dina	16b. Kind of Bu	Business/Industry			
Completed	(Specify only highest gra Elementary/Secondary (0-12)	college (1-4or	5+)		retired)	nkaig					
Con		4						CATION			
Be	17. Father's Name (First, Middle, Last,			18. Mother's Na ELVIRA	me (First, Middle,	Meiden Sumem	e)				
10	ALFONSO BORGES					T 0 - 2 - 0 - 1					
	19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LOURDES RAMOS-IZQUIERDO/DAUGHTER 13904 PLEASANT GROVE CT, SILVER SPRING, MD										
-	20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City										
	1 ☐ Burial 2X Cremation 3 ☐		cemeter	y, crematory or oth	er place)						
	4 Donation 5 Other (Special		EVERL	Y CREMATO		OCT 31		FAX, VA			
BOUG	21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHINES—RINALDI FUNERAL HOME 11800 NEW HAMPSHIRE AVE, SILVER SPRING, MD										
n	23a. Part1. Enter the disease or com shock, or heart failure. List only	plications that cause one cause on each I	d the death. Do ine.	not enter the mode	of dying, such as cardia	c or respiratory a	rrest,	Approximat Intervat Bet Onset and	ween		
100	Immediate Cause (Final		GANG	RENE RIGI	HT LOWER EX	TREMITY		1 1	MO		
	disease or condition resulting in death)	ā		consequence of):	II DONDIK DA			1			
Jer			200 to (01 85 8 t	sonaequence or):							
edicai Examiner	Sequentially list conditions.	b. —	Due to (or as a	consequence of):							
Ä	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
dica	that initiated events resulting in death) Last	C	Due to (or as a o	consequence of):							
3		d						1			
Physician/M											
ysic	Part II. Other algnificant conditions of	contributing to death b	out not resulting In	the underlying cau	use given in Part I.			ntribute to the cause			
	SEVERE PERIF	HERAL VAS	CULAR DI	SEASE		10	Yea 2□ No	3 Probably 4	Unknown		
Completed by							an autopsy ormed?	24b. Were autopsy available prior completion of	to		
Idm							39-	of death?			
00	25. Was case referred to medical examiner?	Hospital: V			Other	eath (Check only o					
5: To	1 ☐ Yes 2 ☑ No 27. Menner of Death	149J Inpati		tpatient 3 DOA	4 Li Nursing	Home 5 Resi	dence 6 Oth how injury occur				
fication:	1 Netural 5 Pending investigation			М	c. tnjury at Work? 1 Yes 2 No						
1	3 ☐ Sulcide 6 ☐ Could not be determined	200. Place of in	jury - At home, fa	rm, street, factory,	office	28f. Location (Street and Numb wn, Stete)	per or Rural Route Nur	nber,		

29a. Certifier (Check only one) McCordifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner at a deeth occurred at the time, date and place, and due to the cause(s) and manner at a deeth occurred at the time, date and place, and due to the cause(s) and manner at a deeth occurred at the time, date and place, and due to the cause(s) and manner at a deeth occurred at the time, date and place, and due to the cause(s) and manner at a deeth occurred at the time, date and place and place and place are the cause(s) and manner at a deeth occurred at the time, date and place and place are the cause(s) and manner at a deeth occurred at the time, date and place and place are the cause(s) and manner at a deeth occurred at the time, date and place and place are the cause(s) and manner at a deeth occurred at the time, date and place are the cause(s) and manner at a deeth occurred at the time, date and place and place are the cause (s) and manner at a deeth occurred at the time, date and place are the cause (s) and manner at a deeth occurred at the time, date and place are the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and

29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

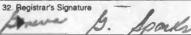
30. Name and address of person who completed cause of death (Item 238) (Type, Print)

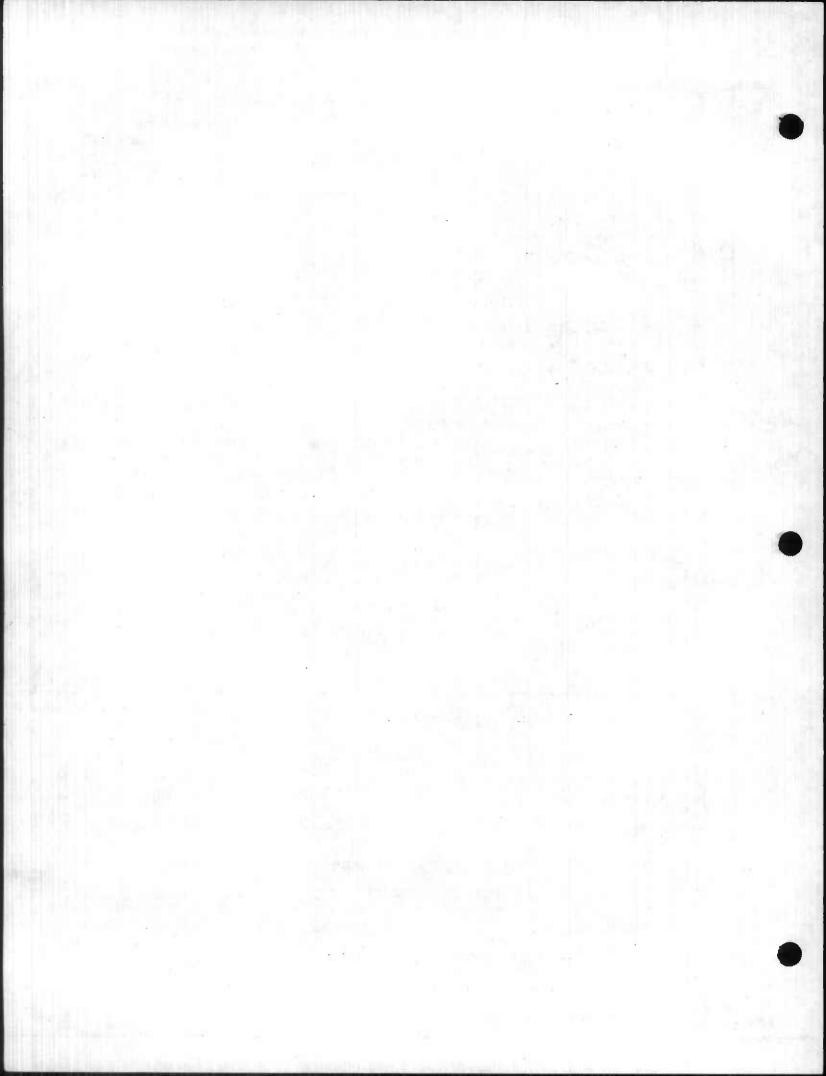
2309 SHOREFIELD RD, WHEATON, MD 20902 MYRON L. LENKIN

State Registrar

Medical Cel

31. Date filed (Month, Day, Year) NOV 0 1 2000





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State of Maryland / Department of Health and Mental Hygiene

					(Certificat	e of	Death		R	eg. No.	U	104/	5	
	1. Decedent's Name	(First, Middle	Last)					41		2. Dete of Deal Month	th Day	Year	3. Time of	Death	
_	Margaret	Louise	CARPENT	TER						nov	3	2000	11.08	Am	
r	4a Facility Name (If	not institution,	give street and n	ium <i>ber</i>)				4b. City, To	wn, or L	ocation of Death	4c. Count	y of Death			
Medical Certification: To Be Completed by Physician American Directors as the burial-fransit of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principl	Washingto				to a h tah	day) If Under	1 Voor	Hage				hingt	-	5	
	5. Sociel Security No.	139	6. Sex 1 ☐ M 2 ☒ F	7. Age (In yrs. 63	Yt	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, April 18	Year)	Cou	place (State or ntry) 11and	rereign	
1	Usual Residence of 10a. State	10b. County		10c. Cit	ty, Town	or Location] .	10d. Inside Cit	y Limits	
					**		4F)			MXYes 2					
ŀ	Maryland 10e. Street and Num		ngton		на	gerstow 10f. Zig				1	ntry?				
			0					740		10g. Citizen of What Country?					
ŀ	11 W. Ba.	ltimore	12. Was De	cedent Ever in U	I,S.	13. Was Dece	21740 U.S.A.								
	1 Never Marrie		Armed I	2 No Sive		If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:						ick, White, fy: W]	etc. hite		
		15. Decedent's	s Education		16a. D	Decedent's Usual Occupation 16b. Kind of Business/I							dustry		
		fy only highest	grade completed	(1-4or 5+)	((Give kind of work done during most of working life. DO NOT use retired)									
	12	(0-12)	College			Home	mak	er			Her ow	n hom	ie		
17. Fether's Name (First, Middle, Last)							18. Mothe	r's Nam	e (First, Middle, I	Maiden Suma	m <i>e)</i>				
Clarence Best Beulah Trumpower										r					
19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zi											o Code)				
	Elwood A	. Carpe	nter, Si	./Husba	nd	11 W.	Bal	timore	St	reet Ha	gersto	wn, M	ld. 217	40	
	20a. Method of Disp	osition		20b. F	Place of D	Disposition (National Crematory or Control	ne of other pla	ca)		Date	20c. Location	- City or T	own, State		
1 Buriel 2 Cremation 3 Removal from Stale 4 Donation 5 Other (Specify) Greenlawn Memorial Park 11/6/00 Hagerstown, Maryla												land			
21. Signature of Funeral Service Licensee 22. Name and Address of Fecility 23. Name and Address of Fecility 24. Name and Address of Fecility Minnich Funeral Home															
Fru Works 415 E. Wilson Blvd. Hagerstown, Md. 21740															
+	23a, Pert1, Enter th	e diseese, or o	complications the	t caused the deet	th. Do no							,	Approximate Interval Bety	•	
Immediate Cause (Final disease or condition resulting in death) a. Cardio respiratory Failure Fow Days Due to (or as a consequence of): Advance Cancer Ovariar/Lymphone For other												Days			
Sequentially list conditions. Due to (or as a consequence of):											awni				
	if any, leading to im- cause. Enter Under Cause (Disease or I that initiated events	njury	c. /	ena	/	Fannsequenca of):	il	we				1	Far	hoo i	
	resulting in death) L	ast	d. 1	type	at	ens	-	ر ا ر				1	Fran	Trans	
	Part II. Other signifi-	cant condition	ns contributing to	death but not res	sulting in t	he underlying	ause gi	ven in Part I		23b. Did tobacco use contribute to the car			to the cause o	of death?	
	A	Res	wia.					FIO.		1□ Y	86 2 No	3□ Pro	obably \$8	Unknown	
								9 = 1	-	24a. Was a perform	n autopsy med?	an Co	Vere autopsy fivallable prior to ompletion of confideath?	0	
										1 🗆 Y	es 2000	1	□Yes 25%	No	
	25. Was case referre	ed to medical						26. Place	of Dea	th (Check only or	ne)				
	examiner?	Ño	Hospital:	Inpatient 2] ER/Outp	patient 3 De	OA Ot	hor:		ome 5 Resid		ther (Speci	ity)		
	27. Manner of Death 1 Natural 2 Accident		28a. Dat (Mc	e of Injury onth, Day Year)	28b. Tir		28c. Inju			28d. Describe h					
	3 Suicide 4 Homicide	6 Could no determine	ned 288. Pla	ca of Injury - At h Iding, etc. (Specif		n, street, factor	y, office			281. Location (S City or Town		ber or Rui	ral Route Num	ber,	
	29a. Certifier (Check only one)		xaminer: On the							and due to the c red at the time, d)	
	29b. Signature and t	title of certifier	bertal .					se number			9d. Date sign				
	MAL	lastu									. 57	D			
30 Name and address of person who completed cause of death (Item 23a) (Type, Print) TANVIR-A. FASHA MD 376 MILL ST. HAGERS TOZON MD 21746															
	31. Date filed (Monti	n, Day, Year)		Registrar's Signal			par				,				
4	1,	IO V O U	LUUU	1		10 10	TUNE	Told							

DHMH 16 Rev 6/95

Funera Directo

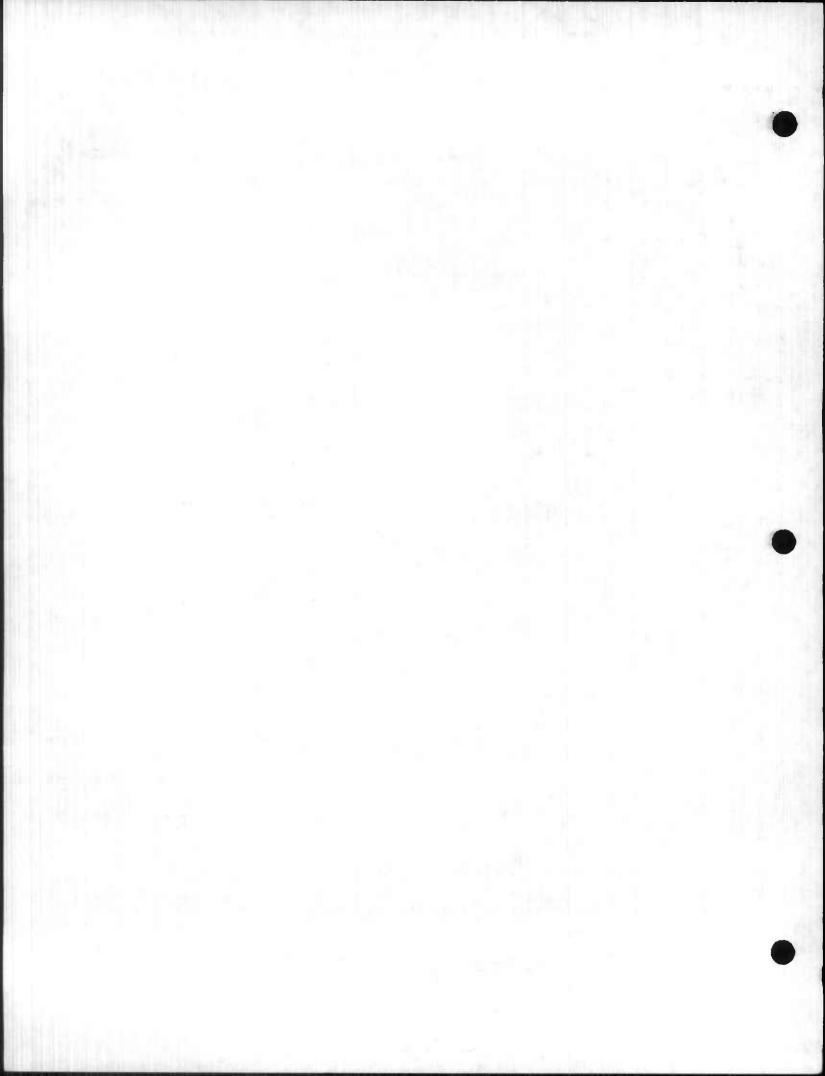
Physician /Medica Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit

Division of Vital Records, P.O. Box 68760.

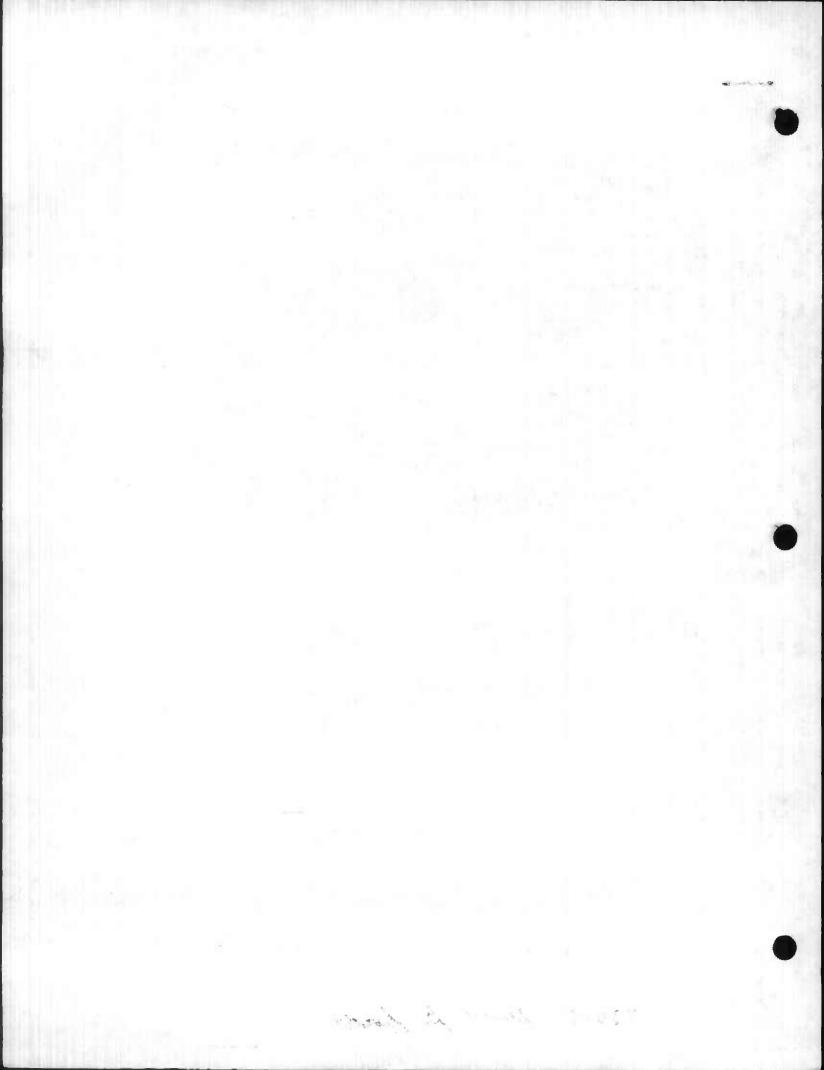
arpenter



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	1 # 26	State of Maryland / Department of Health ar Separation Physics PCC 10-30-2000 cr Certificate of Death			36476			
Am	end # 26	1. Decedent's Name (First, Middle, Last) Certificate of Death	2. Date of Des		3. Time of Death			
	Physician /Medical	Mary E. Calholin	Month 1 O	08 2000	7:15 PM			
	Examiner	4n Contine Name (If not institution aire street and number)	n, or Location of Death					
			ashington		George's			
	Funeral	5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Yeer If Under 24 Montha Days Hours	Min. (Month, Day		irthplace (State or Foreign Country)			
	Director	577-36-9798 74 Yrs. 74 Usual Residence of Decedent	Nov 11,	, 1925 So	uth Carolina			
	yland Bow	10a. State 10b. County 10c. City, Town or Location		10d. tnaide City Limits				
	the Ma 28er's notified	Maryland Prince George's Ft. Wash	ington		1j@Yes 2□No			
	23e or 25e-f : ust be notified			10g. Citizen of What 0				
020	alf, or hans Examiner in Dy Funer	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1	n? (Specify Yea or No- Puerto Rican, etc.)	14. Race - An Black, Wh Specify: B				
21215-0020	ad within 72 ho ygiene. wer than "neture it, the Medical. Completed	15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)		16b, Kind of Busines				
			s Name (First, Middle,	Governm	ent			
Maryland	o Be		mmie Calho					
7	thould Man marks marks To	19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number			, Zip Code)			
ž	2000	Martha Diggs/Aunt 55 Randolph Avenue	, Jersey C:	ity, NJ 07	305			
ore,	of Her	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City	or Town, State			
altimore	Page Internation	1 Resurrection Cemetery	10/11/00	Clinton,	Maryland			
Balt	Departi Importa any inj ance	21. Signeture of Funeral Service Licensee 22. Name and Address of Facility 3910 Silver Hil.	nouges and		Funeral Home			
1		23a. Paft1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as constant, or heart failure. List only one cause on each line.			Approximate Interval Between			
10	Physician /Medical Examiner	Immediate Cause (Final diaease or condition			Onset and Death			
п	1.0	Due to (or as a consequence of):	THE WAR					
	axecuted in and ial-transit	BOWEL OBSTRUCTION	3N					
ć	be axecuted ician and burial-transit				9.4			
8760,	physician the buria	C. Due to (Or as a consequence of): That initiated eventa resulting in death) Last	C					
9								
Вох	deeth certifi e attending ed for use as	0						
	at the deeth certing by the attending etached for use a Physician/M	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Dld t	obacco usa contribu	ita to the causa of death?			
0	that the detected detached		101	/aa 20 No 3□	Probably 4 Unknown			
Records,	been sign should be			an autopsy 24l	b. Wera autopsy findings available prior to completion of cause of death?			
	The lay		101	es 2 No	1 Yes 2 No			
	certificate rector, pag	25. Was case referred to medical 26. Place of	of Deeth (Check only o	0				
of V	2 00 7	examiner? 1 Yes 2 No	eing Home 5 🎇 Resid	lence 6 Other (S)	pecify)			
0	After thi funarel tunarel			now injury occurred				
Division	To the Hospital or Attending P within 24 hours shed death. To the Funeral Director: After completely filled in by the funar Medical Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)			Rurel Route Number,			
	w Hospital n 24 hours w Funeral pletely filled edical C		place, and due to the of occurred at the time,	ceuse(s) and menner dete end piece, and d	as stated. fue to tha cause(s)			
	ithin 2 of the omple			29d. Date signed (Mo	onth, Day, Year)			
	F3F8							
	(2)	30. Name and address of peraon who completed cause of death (Item 23a) (Type, Print)	010	20-1	- 00			
	0	30. Name and address of peraon who completed cause of death (Item 23a) (Type, Print) Dr. Paul Mc Koul, Washington Hosp. Ctr. (ances Ir.	Stitute				
	State	31. Date filed (Month, Dey, Year) 32. Registrer's Signature						
	Registrar	OCT 3 0 2000 Bereine S. 1200						

DHMH 16 Rev 6/95

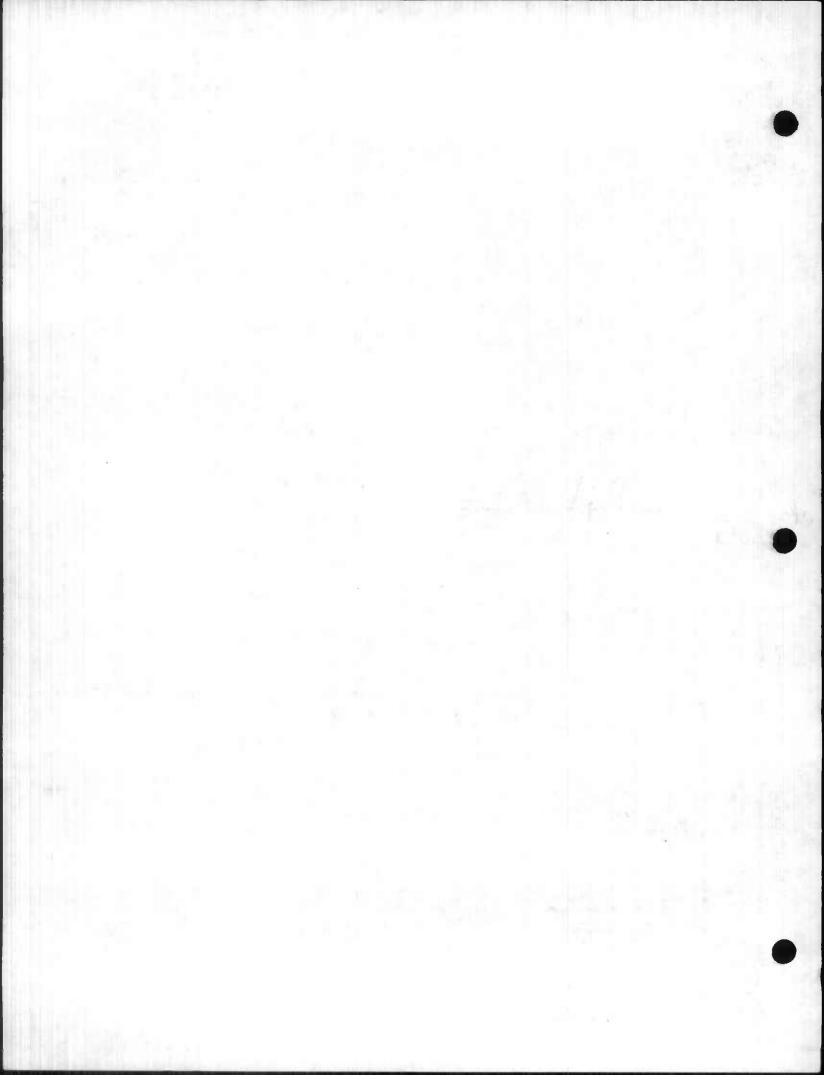


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State of Maryland / Department of Health and Mental Hygiene

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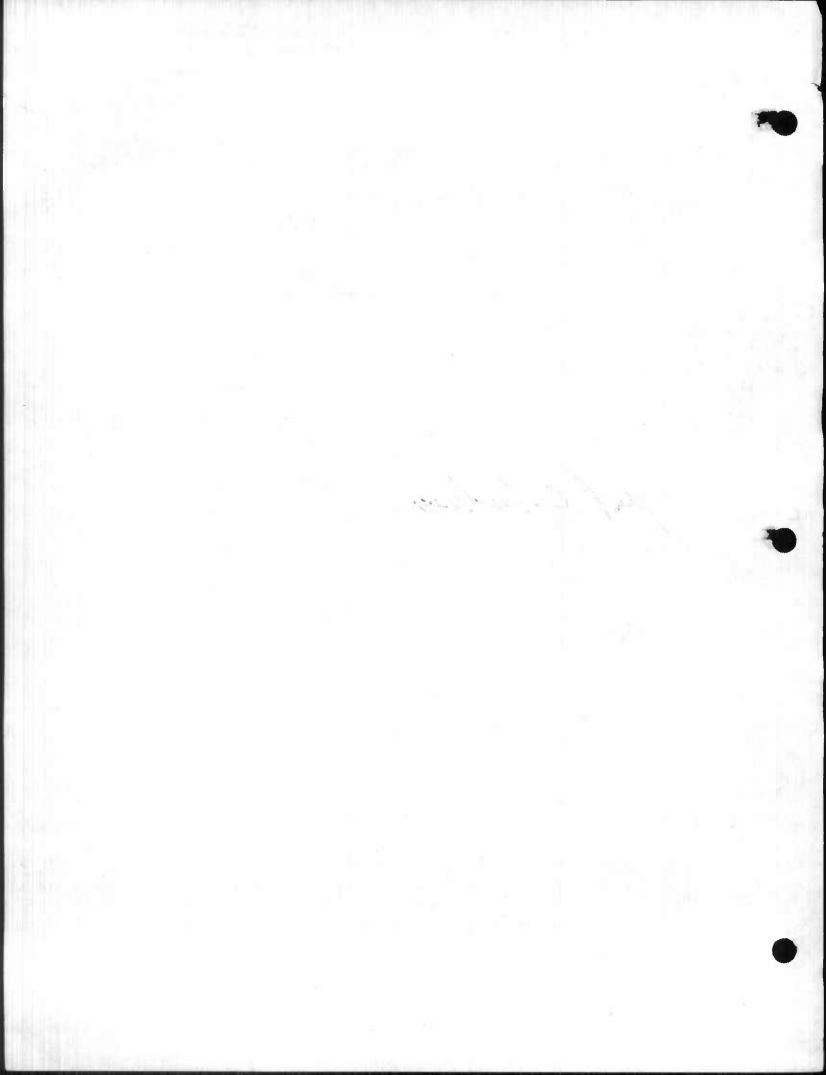
				Ce	rtificate of	Death		Reg. No.		V 0 1 1 1			
		1. Decedent's Name (First, Middle, L	ast)				2. Data of D		Day Year				
	Physician /Medical	Brenda Lee	Cla	rk			Octob			6:15 am			
	Examiner	4a Facility Name (If not Institution, g.	ive street and number)			4b. City, Town, or L	ocation of Dea						
7.0		9612 51st P1	ace			College	Park	Prin	ce Ge	eorge's			
-	Funeval			e (In yrs. last birthday)	r If Under 24 Hrs.			lace (State or Foreign					
	Funeral Director	215-68-9379	1□M 20 F	39 Yrs.	Months Days	Hours Min.	8. Data of Bi						
L.,	Director	Usual Residence of Decedent		33		11	July 2	, 1961	Maly	yland			
	and and	10a. State 10b. County		10c. City, Town or Le	ocation				10	Od. Inside City Limits			
	f show and at	Manyland Brings	Caamaala	Ca11.aa	Develo					1 X Yes 2 □ No			
	or 28s-f	Maryland Prince	George's	College	10f, Zip Code			10g. Citizen of V	What Count	to/2			
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la	Mental be when an arked o arked o arked o	John S. Clark				Bett	e Lorr	aine Cl	ark				
Maryland	and)	19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ng Address (Stree	et and Number or Ru	ral Route Numi	ber, City or Town,	State, Zip	Code)			
Σ	olth a	John S. Clark, II	- Brother	9614	51st Pla	ce, Colle	ge Park	. Marvla	nd 2	20740			
ē,	H He atto	20a. Method of Disposition		20b. Place of Disp	osition (Name of		Data	20c. Location -		wn, State			
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-	Examiner	fmmediate Cause (Final disease or condition resulting in death) a. COMMMY AMOUNT NIGORE Due to (or as a consequence of):											
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	131	30. Name and address of person who	completed cause of d	eath (Item 23a) (Type	11 100	11 1	n	1	6.	101) and			
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State of Maryland / Department of Health and Mental Hygiene 00 36478

			Ce	ertificate of	Death	R	leg. No.		00770	
	1. Decedent's Name (First, Middle, Las					2. Data of Dea Month		Yaar	3. Time of Death	
Physician /Medical	Ronald Da	vid Choate				Octobe	-	2000	02:25 A.N	
Examiner	4a Facility Name (If not institution, give	street and number)			4b. City, Town, or	Location of Death	4c. County	of Death		
		gton Medical		shington			George's			
Funeral Director	5. Social Security Number 6. St 579–58–01.94	7. Aga (In yn	5. last birthday 54 Yrs.	Months Days	If Undar 24 Hrs Hours Min		1946		place (State or Foreign Ington, D.C.	
pu .	Usual Residence of Decedent 10a. State 10b. County	100.0	city, Town or L	ocation				1	Od. Inside City Limits	
with the Maryle is or 28a-f aho be notified at	Maryland Prince Geo		,	Fc	ort Washing				Yes 2□No	
th with th	10e. Street and Number 2700 Shawn Court			10f. Zip Code	20744	1	10g. Citizen of What Country? U.S.A.			
72 hours after death with the Maryland netural; or fame 23a or 28a-1 show deat Exercises must be notified at setel by Funeral Director	11. Marital Status 1 Nevar Marriad 2 Married 3 Widowed 4 Divorced	12. Was Decedent Evar in Armed Forcas? 1 ⊠Yes 2 □ No If Yes, Give Yaar or Datas:	U,S. 13	Was Dacedent of H If Yes, specify Cub 1 ☐ Yes XX No	dispanic Origin? (an, Mexican, Pua Specify:	Specify Yes or No- rto Rican, atc.)	Bla	ca - Americ ck, White, v: Black	etc.	
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should be nd Mental marked o urmatic ev	Johnny CHo	ate				Juanita 1	Walker			
d 2 should be file th and Mental Hy 7 Is marked oth traumatic evant	19a. Informant's Name/Relationship (7	r, City or Town		Code)						
4265	Mrs. Ruth Choate (Wif			Shawn Court	Fort Was		-			
60 mg 40 U	20a. Mathod of Disposition	Ramoval from State Ma	ryland	position (Name of ematory or other pla Veterans Ce	metery	11/6/2000	20c. Location Chelten			
permit. Page Department of Important: If it any Injury or once.	21. Signature of Funeral Service Licen	See buda	10-		UNERAL HO	E, INC.	MICN D	2 20	019	
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certificate rector, pag	25. Was case referred to medical axaminer?			1-12		eath (Check only o	ne)			
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To the Hospital or Attendit within 24 hours after death. To the Funeral Director. A completely filled in by the it Medical Certificati	29e. Certifier 1 Certifying Phy (Check only 2 Medical Exam	raician: To the best of my kr iner: On the basis of examinand manner stated.	nowledge, dee	oth occurred at the ti	me, dete and place	ce, and due to the courred at the time, of	cause(s) and modele end place,	enner as a	o the cause(s)	
Vithin To the comple	29b. Signature and title of certifier			29c. Licans	sa number	1	29d. Date signe	ed (Month,	Day, Year)	
P 5 P 0	11/1	11: 1	27		CME		Octob	20r 2	6 2000	
(6)	30. Name and address of person who o		, , ,	e, Print)	O.C.M.E.				6, 2000	
()	THEODORE.	MIKIT	111	Penn Stre	eet, Bal	timore, M	aryland	1 212	01	



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 36479 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death 3. Time of Death October 30,2000 2320 Clauges Clinton 4b. City, Town, or Location of Death 4a Fecility Nema (If not institution, giva street and number) 4c. County of Death Prince Georges Hospital Center Cheverly Prince Georges Hours Min. February 4,1914 Virginia If Under 1 Year 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foreign 1□M 20 F Months Days 577-28-9037 86 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location 10b. County 1 ☐ Yes 🏋 【文 No Maryland Prince Georges Mitchellville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11805 Jester Court 20721 U.S.A. 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Rece - American Indian, Black, White, etc. 11. Merital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Ricen, etc.) 1 Never Married 2 Married Specify: Black 1 Yes 2 No Specify: Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondery (0-12) Social Service Representative Dept. of Human Services 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Mattie Draffin Henry Battle 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Deatra T. August/Daughter 11805 Jester Ct. Mitchellville, MD 20721 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State XXBurlel 2 Cremetion 3 Removal from State Ft. Lincoln Cemetery November 3,2000 Brentwood, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Ft. Lincoln Funeral Home 21. Signature of Funerel Service Licenson 3401 Bladensburg Rd. Brentwood, MD 20722 01000 23a. Part. Enter the double, or complication that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onsat and Death Immediate Cause (Final disaase or condition resulting in deeth) 5FP515 Due to (or es a consequence of): Due to (or es e consequence of). 1/TN Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yee 2 No 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yas 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f ahow

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental hygiena.
Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, or Medical Examples.

Baltimore, Maryland 21215-0020

Directo

Funeral

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death

attending physician and for use as the bunal-transit signed b certificete ha

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Physician: this Hospital or Attending Director: /

Physician/Medical Examiner þ Completed Be 2 Certification:

edical

24 hours To the Hosp within 24 hor To the Fune completely fi

Registrar

Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 25. Was case referred to medicel 26. Plece of Death (Check only one) Hospital: 1 Inpatlant 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accidant 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 6 Could not be 3 Sulcide 28e. Plece of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide 29a. Certifier 1 Cartifying Phyaician: To the best of my knowledge, death occurred et the time, date and place, end due to the ceuse(s) end menner as stated.

2 Madical Examinar: On the bests of examination and/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stated. (Check only one)

29c. License number 29b. Signature end title of certifier

29d. Date signed (Month, Day, Year) 10-31-00

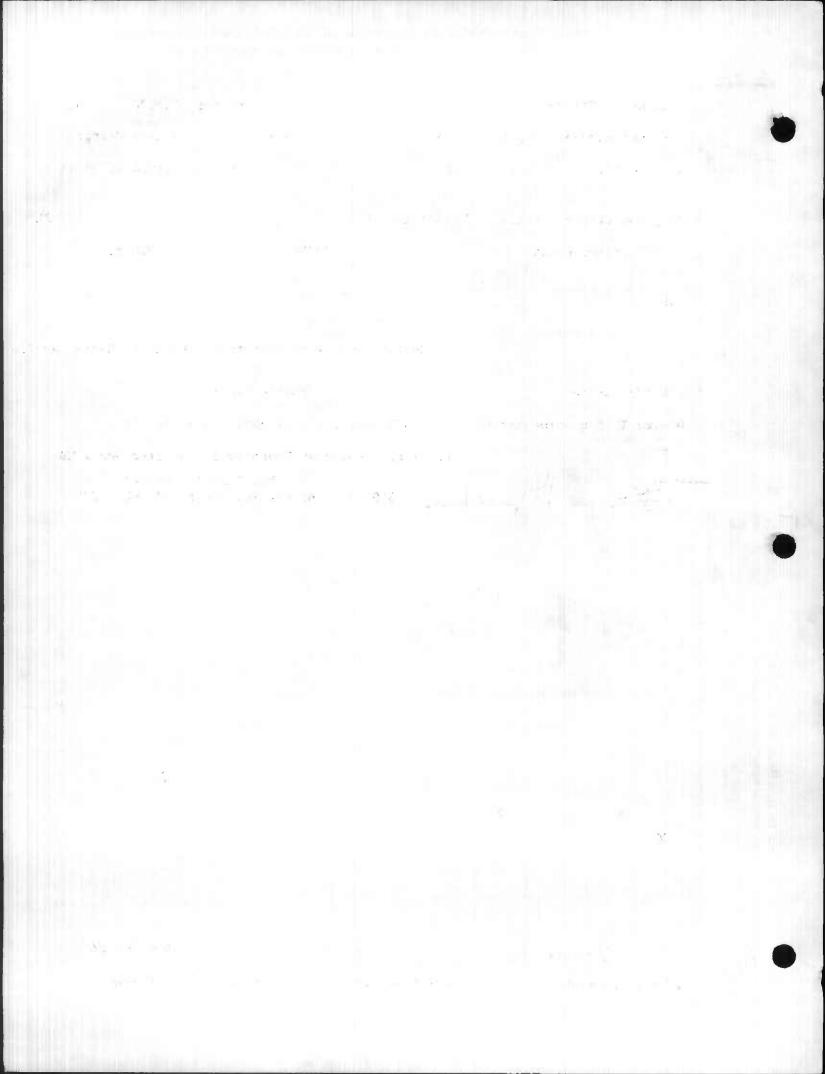
30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) BERHANE 1510N

3001 HOSPITAL

CHEVERLY, MD 20784

31. Dete filed (Month, Dey, Yeer) NOV 0 2 2000 32 Registrer's Signature Spall

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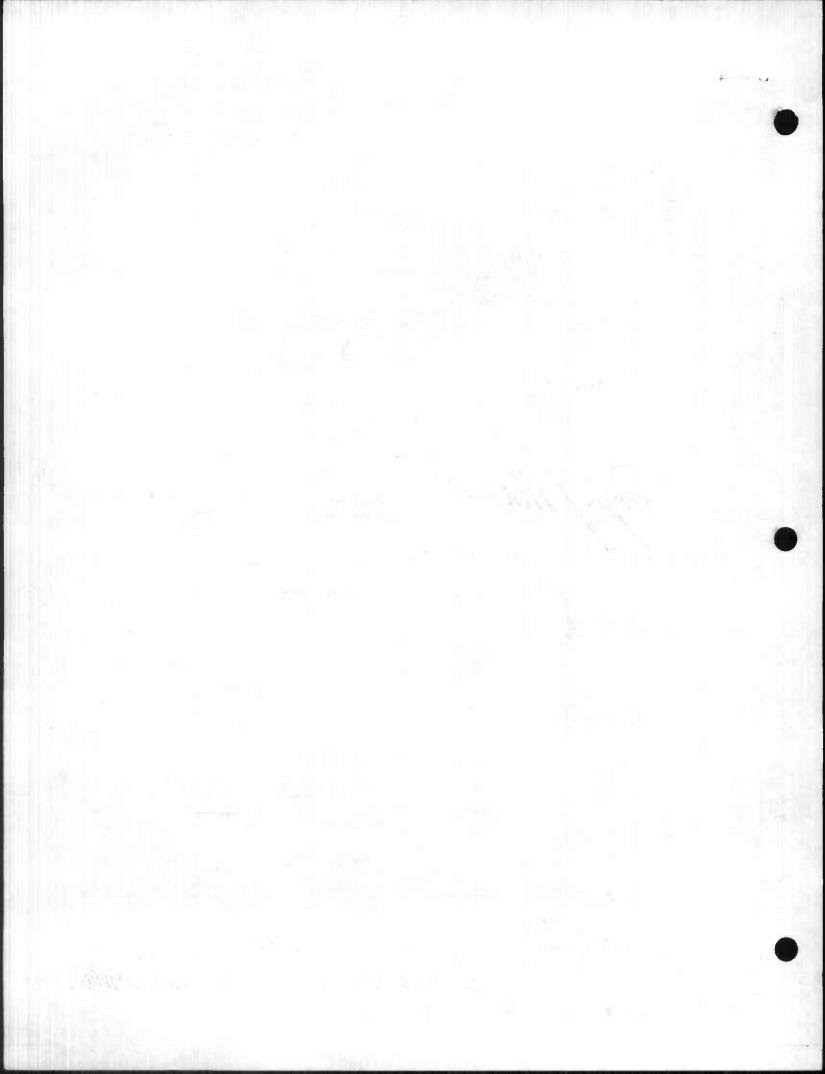


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #26.Per Phys.PGC 11-3-2000 cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Phillip Conley **Physician** George 7:33am /Medical 10-25-2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** LeonardTown St Mary's St Mary's Hospital If Under 1 Year | If Under 24 Hrs. | 8. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** XXM 2DF 59 318-34-6255 Director 12 - 30 - 40Illinois Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Great Mills St Mary's Md 1 ☐ Yes Ž No Director 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20634 U.S.A. 21708 Chancellors Run Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Xes 2 No If Yes, Give Year or Dates: 1 Never Married XIXMarried Specify: White 21215-0020 ò 1□ Yes 2℃No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4years Educater Education 12 Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Pages 1 and 2 should be fit ment of Health and Mental H ant. If itsen 27 is marked oth lury or other traumatic even Be Levern Furlong George John Conley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21708 Chancellors Run Rd Great Mills Charlene M Conley Baltimore, 20c. Location - City or Town, State 3 4 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 1 Burial 2 Cremation 3 Removal from State Chesapeake Crematory 10-30-00 Beltsville Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Funeral Service 21. Signature of Fungral Service Licental 1601 Kenilworth Ave NE Wash DC disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in turns, List only one cause on each line. 23a. Part f. Enter the shock, or hear Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Find disease or condition resulting in death) Examiner Examiner Artery The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medicai the Due to (or as a consequence of): USe as 1 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? lei 1 Yea 2 No 3 Probably 4 Unknown Division of Vital Records, Ą 24b. Ware autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy certificate has 1 ☐ Yes 20 No 1 ☐ Yes 2 No Attending Physician: director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home ST Residence 6 Other (Specify) Certification: To 1 Yes 2 No this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No s after death.
I Director: A
od in by the fi death 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. edicai 29a. Certifie (Check only one) 29b. Signatura 29c. License number 29d. Date signed (Month, Dey, Year) 0 52196 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 2050 Wildewood Center, California, MD 20619 1,0BALL, MD 32 Registrar's Signature 31. Date tiled (Month, Day, Year) State

DHMH 16 Rev 6/95

Registrar

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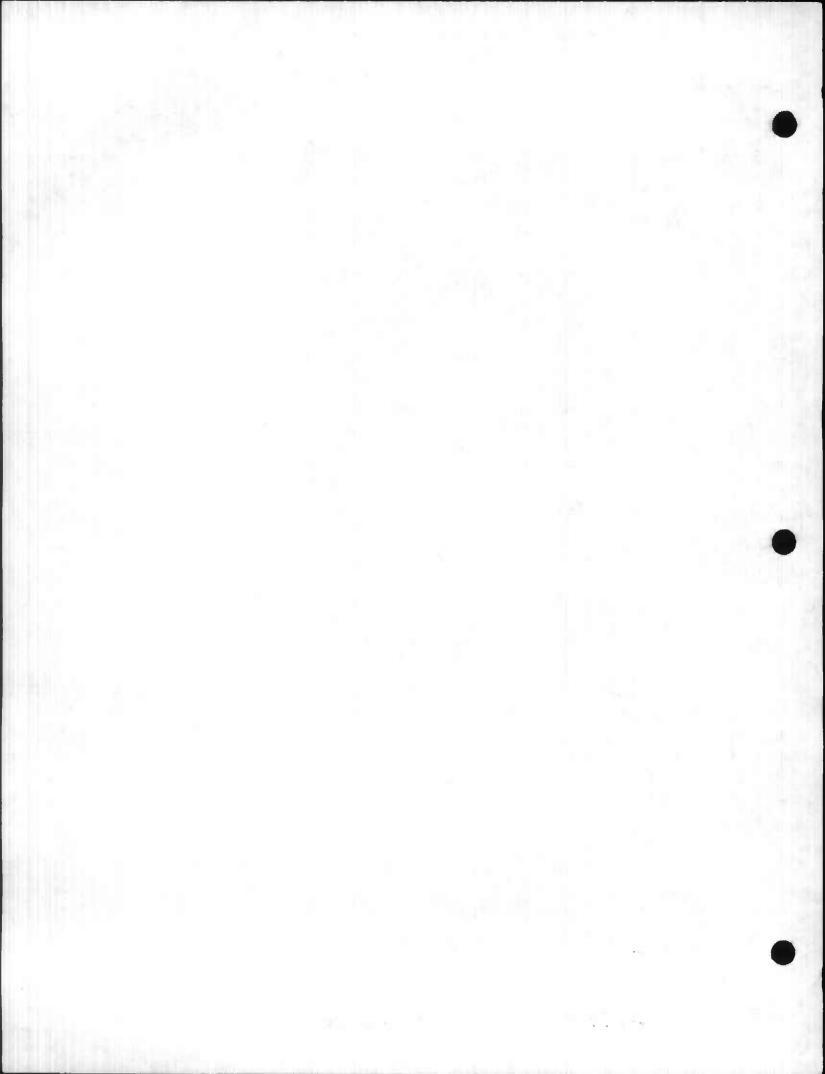
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Examiner		s LaPlat					La Plata		Cha	rles	
	5. Social Security N		Sax	7. Age (In yrs. las	t birthday)	If Undar 1 Yea		8. Date of Birt			lace (State or Foreign
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D 76064 October 30, 2000

30. Name and address of person who completed cause of death (Itam 23a) (Type, Print) & Go LDEN BEACH RD CHARLOTTE HALL, MD 20622

31. Date filed (Month, Day, Year) State NOV 0 3 2000 Registrar

32. Registrar's Signature

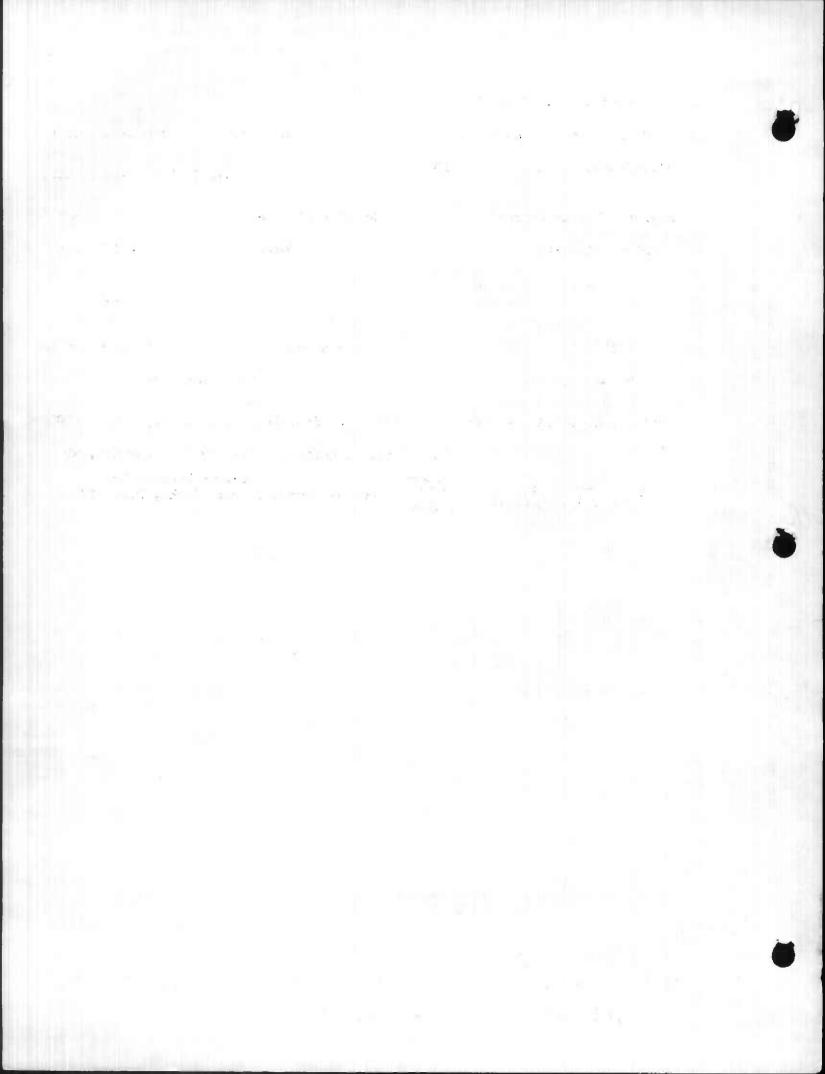


State of Maryland / Department of Health and Mental Hygiene

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5/	TSION BERHAM	VE 30	OI HOSI	PITAL .	DRIVE		CHEVE	ERLY 1	MD	20784
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DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Pay 2000 ar November 4:27 PM **Physician** Margaret Dorothy Clark /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Death **Examiner** Clinton Prince Georges Southern Maryland Hospital 8. Dete of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthdey) 79 Yrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours 218-16-3236 10 M AGF Yrs. Director July 8, 1921 Maryland Usual Residence of Decedent 10a. Stete 10c. City Town or Location Clinton Prince Georges 10d. Inside City Limits e then "netural", or Nerse 23s or 23s-1 sho the Medical Examiner must be notified at Maryland 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20735 5707 Skye Drive Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Black 1 Yes 2 No No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2) No Specify: Specify: by 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper Janitorial 18. Mother's Name (First, Middle, Maiden Sumame)
Mamie Ann Johnson 17. Father's Neme (First, Middle, Last) Be 8 John Milton Clark 0 19a Informant's Name/Reletionship (Type, Print)
Mary Munson - Daughter 19b. Mailing Address (Street and Number of Rural Route Number City of Town, State Cip Sade) Pages 1 and 2 si ment of Health an I and important if Health I have Z7 is any injury or other D05s. -20b. Placa of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition ↑ Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 11-06-2000 Clinton, MD Resurrection Cemetery 22 Name and Address of Facility
George P. Kalas Funeral Home 21. Signature of Puneral Service Licensee 6160 Oxon Hill Road, Oxon Hill, Maryland 20745 alab and inter the disease, or complications I at daused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, or heart tailure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical 2 Due to (or as a consequ 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown agned by þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury at Work? Certification: 5 Pending Investigation 1 Netural 1 Yes 2 No 2 Accident Director 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 HomicIde 8 24 hours Funeral edical 29a. Certifier 1<mark>☑ Certifying Physician:</mark> To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the To the F 29d. Date signed (Month, Day, Year) 29b. Signature and title of confine

State Registra

NOV 03 2000

pleted cause of death (Item 23a) (Type Print) 32. Registrar's Signature

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nov 11,2000

Surratts Rd. clinton,



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AMEND#19B 10/27/00 AACO Health

OIIII T	Certificate of Death	Reg. No.	3. Time of D
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tate of Mar	yland / Department of Health and M	lental Hygiene	00100

Physici /Medic Examin

Funeral Director

Pages 1 and 2 should be filed within 72 hours shar

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

TS AVENUE Was Decedant Evar in U American Science TS AVENUE Was Decedant Evar in U American Science Was Decedant Evar in U Am	last birthday) Yrs. ty, Town or Loca BALTTM J.S. 13. Wa If Y 16a. Deceder Give kir	# Under 1 Yaa Months Days tion ### Total Code ### Total Cod	BALTI If Under 24 Hrs Hours Min 29 Hispanic Origin? (5 ban, Mexican, Puer	Month, Day, OCT . 3	4c. County CIT'Y Year) 1966 Og. Citizen of W	9. Birthplace (State or Foreign Country) 10d. Inside City Limit 1 Yes 2 N
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DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

OCT 2 7 2000

ORIGINAL

32. Registrar's Signature

OCT 27 2800 ----

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Date of Death 3. Time of Death **Physician** 1230 P 1, 2000 Nancy Werntz Coyner November /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner 142 Prince George Street Anne Arundel If Undar 1 Year 8. Data of Birth (Month, Dey, Year) 7. Aga (In yrs. last birthday) **Funeral** Deys 1□M 2♥F 212-16-8588 83 Yrs. 16,1917 Director Maryland Usual Rasidence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or flems 23s or 28s-f show the Medical Examiner must be notified at MD 1X Yas 2 No Anne Arundel Ann apolis Directo 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 142 Prince George Street 21401 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Giva 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0020 1 Yas 2X No Specify Specify: White by 3 ₩ Widowed 4 Divorced Year or Datas: Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Homemaker Own Home 18. Mothar's Nama (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Mental is marked Elsie Garner William Werntz 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rurel Routa Numbar, City or Town, Stete, Zip Code) important of Health as Important: If item 27 is a any Injury or other 1 Nancy Coyner Farmer / daughter 6312 Olde Towne Ct. Alexandria, VA. Baltimore, 20b. Place of Disposition (Nama of cematery, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ABurial 2 Cramation 3 Removal from State Cedar Bluff Cemetery 11-4-00 Annapolis, MD. 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signatura of Funaral Sarvice Licent Annapolis, MD 21401 147 Duke of Gloucester St. Lan 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death **Physician** Immediate Cause (Final disaesa or condition resulting in death) /Medical Examiner Physician/Medical Examiner The lew requires that the death certificate be asscuted Sequentially list conditions, if any, leeding to immediata cause. Enter Underlying Causa (Disaasa or injury that initiated evants resulting in death) Last as the burial-tran iptial or Attending Physician: The lew requires that the death certificate be as una filer death.

wetal Director: After this certificate has been signed by the attending physician filled in by the funeral director, page 2 should be detached for use as the burial - 4 68760 Dua to (or as a consequence of) Box of Vital Records. P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yas Àq 24b. Wara autopsy findings available prior to complation of causa of daath? 24a. Was an autopsy Be Completed 2 1 No 1 Yes 1 ☐ Yas 2 ☐ No 25. Was case refarred to medical axaminar? 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No Othar: 4 Nursing Homa 58 Rasidance 8 Other (Specify) Certification: To 27. Manner of Death 28d. Describe how Injury occurred 28b. Tima of Injury at Work? Division 5 Pending Invastigation Neturel 2 Accident 1 Yas 2 No 6 Could not be 3 ☐ Sulcida 28e. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) 281. Location (Street end Number or Rural Routa Number, City or Town, State) 4 Homicida To the Hospital within 24 hours a To the Funeral C completely filled Hospital 24 hours a Medical 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) (Check only 29c. License number 29d. Data signad (Month, Day, Year)

DHMH 16 Ray 6/95

State Registrar

ORIGINAL

Please Type or Print In Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Dennis Chute M.D. State Registrar

32. Registrar's Signetura 31. Date filed (Month, Dey, Year) NOV 0 9 2000

30. Name and address of person who completed cause of deeth (ttem 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

NOVEMBER 6,2000

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5000 8 0 VOM

AMEND ITEM: #23 PART I, PER PHY G/89 II - D WR Amend Item 9, per F.D. Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 10/17/00, Carroll County, wj1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Tima of Death **Physician** October 13, 2000 Lillian Carrie Cavey 6:10am /Medical 4a. Facility Nema (If not institution, giva street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Westminster Nursing Home Westminster Carroll 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yaar) 9. Birthplace (State or Foraign Nov. 18, 1919 Marry Land 7. Aga (In yrs. last birthday) **Funeral** Deys 1 □ M 2 🖾 F 80 Yrs. Director 216-01-6594 Usuei Residence of Decedent Maryland the Maryland ta or 28a-f show 10e. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Carroll Westminster 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizan of Whet Country? ms 23a 21157 4240 Salem Bottom Road USA Funeral 12. Was Dacedent Evar In U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Giva Yaar or Detes: Hems Was Dacedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puarto Rican, etc.) 14. Race - American Indian, Bieck, White, atc. than "natural", or item the Medical Examiner filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest greda completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 8 .. Pages 1 and 2 should be filed w tment of Health and Mentel Hygier tant: if item 27 is marked other th lury or other traumatic event, In Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Nema (First, Middle, Maiden Surname) Be William Hobson Maude Gultermuth 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. John L. Cavey (Son) 4240 Salem Bottom Road Westminster, MD 21157 20b. Piece of Disposition (Nema of cemetery, crematory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete tX Buriei 2 ☐ Cremetion 3 ☐ Ramovei from Stata permit. Page Department of Important: If any injury or Meadowridge Memorial Park 10/16/00 Elkridge, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funarai Service Licensee 22. Name end Addrass of Facility HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Q. Haight buan Sykesville, MD 21784 (410)-795-1400 23a. Pert1. Enter the disease, or complication that caused the daath. Do not enter the mode of dylng, such as cardiac or respiretory arrast, shock, or heer feliure. List only one ceuse on each lina. Approximate Intervel Between Onsat and Death UROSEPSIS **Physician** /Medical Reccurent Immediate Ceuse (Final Uvinan 6 montas disease or condition resulting in daath) Examiner Due to (or es e consequence of) Examiner HYDRONDEHROSIS The lew requires that the death certificate be executed Sequentielly list conditions, if eny, laeding to Immediata ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting In deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760 URINARY TRACT OBSTRUCTION Physician/Medicai Due to (or es a consequence of): Part il. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detec 1 Type 2 No 3 Probably 4 Ptinknown þ Completed 24b. Wera autopsy findings evalleble prior to completion of ceusa of deeth? 24e. Wes en eutopsy hes certificate 1 Yas 2 TNo 1 Yes 2 No or Attanding Physician: effer death. Director: After this certifica director, Be 25. Wes case refarred to medical exeminar? 26. Place of Deeth (Chack only one) Certification: To 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) funeral 27. Menner of Deeth 28d. Describe how Injury occurred 5 Panding 2 Accident investigation 1 Yes 2 No 6 Could not be datamined 3 Sulcide 28e. Plece of injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) à 4 Homicida To the Hospital within 24 hours a To the Funeral D completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, end due to the cause(s) end mennar as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, dete end place, and due to the ceuse(s) end menner steted. edicai 29e. Cartifier (Check only one) 29b. Signetura and title of certifiar 29d. Data signed (Month, Day, Year) 52035 INTERNIST October 13,2000 ercico 30. Name and eddress of person who completed cause of daeth (Item 23e) (Type, Print) Westminista MD 21157 293 Stoner

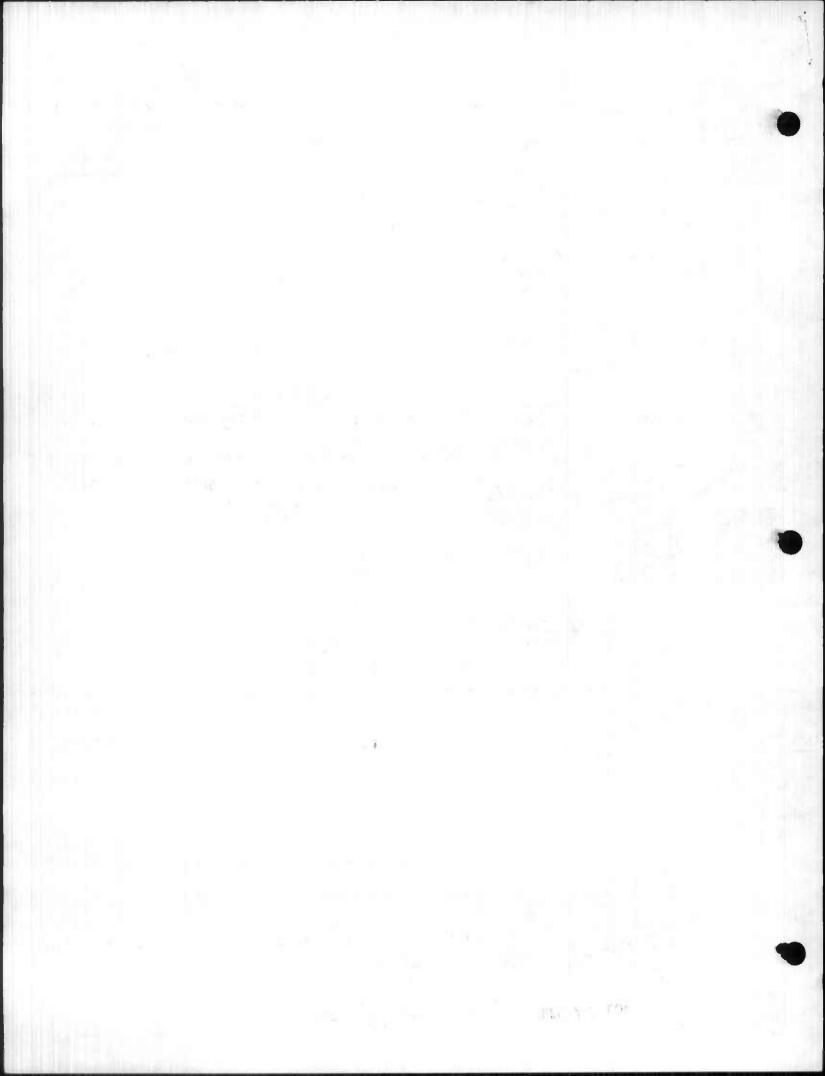
State

Registrar

31. Dete filed (Month, Dey, Year)

OCT 17 2000

32. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Months :

7. Age (In yrs. last birthday)

10c. City. Town or Location

Salisbury

58

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Year October 2000

If Under 1 Yeer If Under 24 Hrs. Months Days Hours Min.

Days

4b. City, Town, or Location of Death

8. Dete of Birth (Month, Dey, Year)

Aug. 5 1942

SALISBURY

4c. County of Death

WICOMICO

Birthplace (State or Foreign Country)

10d. Inside City Limita 1 Yes 2 No

Maryland

	Exa or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28s or 28	edica amine eral etor
ryland 21215-0020	hould be filled within 72 hours after des 5 Mental Hygiens. mirked other than "natural", or flerms.	Wind washing the property of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the con

Physician

Regina Dozier

5. Social Security Number

213-42-0209

10a Stete

Usual Residence of Deceden

4a Facility Name (If not institution, give street and number)

10b. Counts

Maryland Wicomico

PENINSULA REGIONAL MEDICAL CENTER

1 M 2 F

permit. Pages 1 and 2 sho Department of Health and A Important: If Item 27 is ms any injury or other traums **Physician** /Medicat

Baltimore,

213420209

Keging Dozier

Examiner the attending physician and hed for use as the burial-trans been signed by the should be detached cate has this certificate or Attending Physician: Division death. Director

To the Hospital of within 24 hours at To the Funeral D completely filled it

ANTHONY

31. Dete filed (Month, Dey, Year)

Fley

OCT 0 3 2000

10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A 21801 149 Delaware Avenue 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Comple Elementary/Secondery (0-12) College (1-4or 5+) None Domestic 12 17. Fether'a Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Helen Cropper Andrew White 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 149 Delaware Ave. Salisbury, Md. 21801 Roy Dozier (Husband) 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 10 1 ■ Burial 2 Cremation 3 Removel from Stete Salisbury, Md. 4 ☐ Donation 5 ☐ Other (Specify) Green Acres 22. Name and Address of Facility
Stewart Funeral Home 21. Signature of Funeral Service Licensee 821 West Rd. Salisbury, Md. 21801 polications that caused ath. Do not enter the mode of dying, such as cardiec or respiratory errest, one cause on each line. 23a. Pert1. Enter the disease, or complishock, or heart tailure. List only or Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in deeth) emyoparte Due to (or as a consequenca of): Examin larler Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (br es a consequence of) edical Due to (or es e consequence of): Physician/M Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? Completed 1 Ves 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medicat Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 1 Naturet
2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be determined 3 Suicide 28e. Ptece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 20 Medical Examiner On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) 29b. Signature and title of certifie 29c. License number 29d. Dete signed (Month, Day, Year) D005339 00 mo 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

Registrar

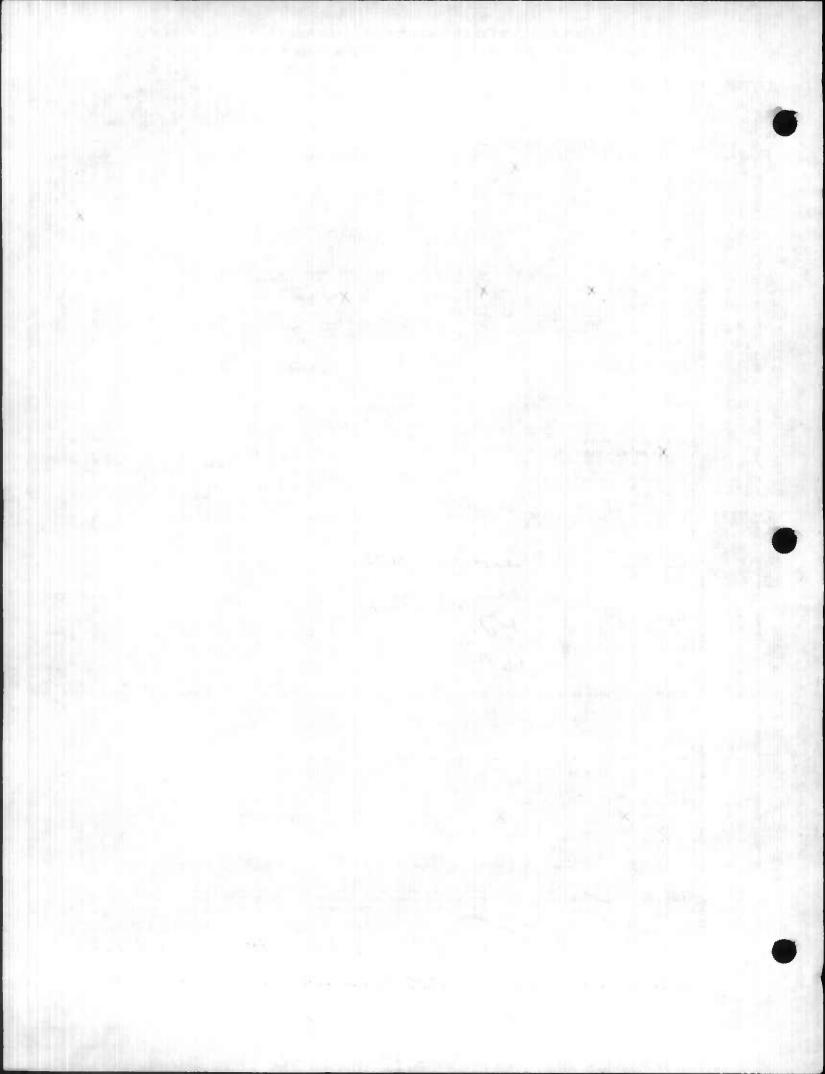
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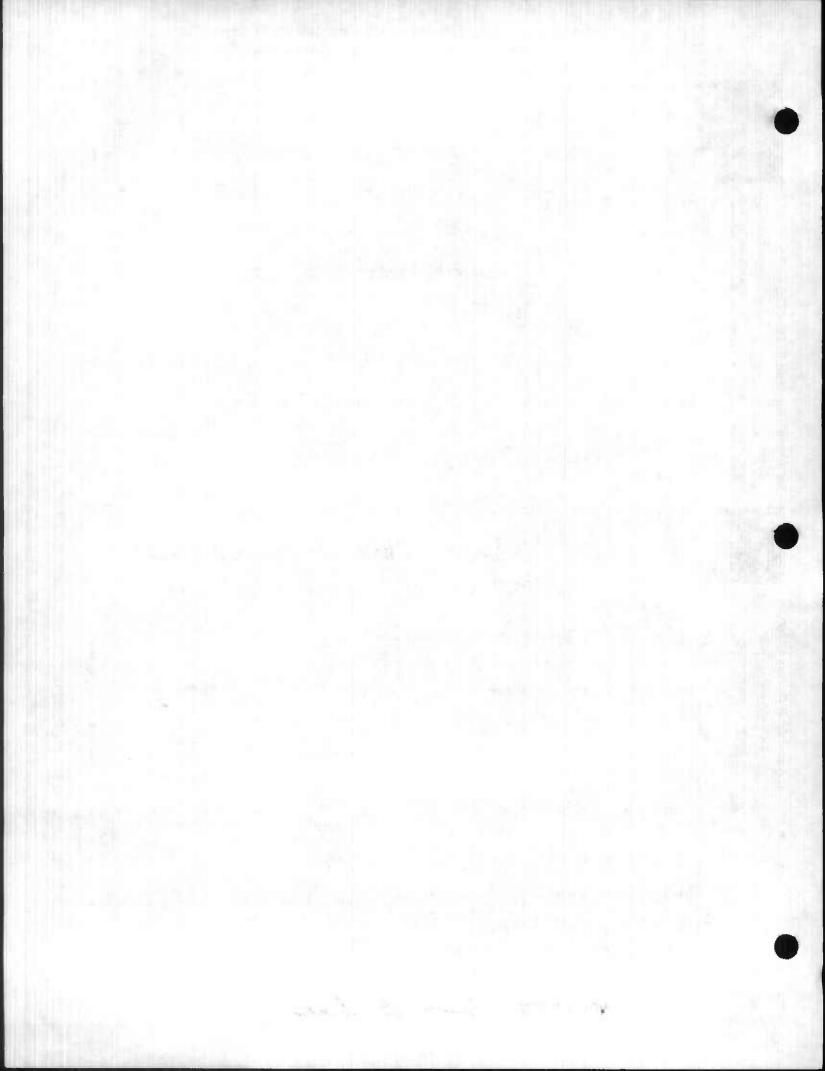
32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

			State of Marylar		artment rtificate			nd M	ental Hy	/giene	3	6491
		1. Decedent's Name (First, Middle, Last)						2. Date of D	eath	Mari	3. Time of Death
	Physician /Medical	EDWARD	RICHARD	DANI	ELSON	1			Month NOVEM	IBER 2,	2000	14:05
	Examiner	4a Facility Nama (If not institution, giva Calvert Memo:		al		1	*		ederi		of Death	
	Funeral Director	-20 10 2010 11	7. Age (In yrs.	last birthdey) Yrs.	If Under 1 Months	Yaar Days	If Under 2 Hours	4 Hrs. Min.	8. Date of B (Month, P Sept	ay, Year) 19	9. Birthp	leca (State or Foraign (ry), NiO
	a Mayland la-f show stilled.al	Usual Residence of Decedent 10a. State 10b. County Maryland Calvert		ty, Town or Lo Lusby	ocation						1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	ath with the Maryla 23e or 28e-f sho ust be notified at rail Director	10a. Street and Number 12869 Bay Driv	ve		101. Zip C	065	7			10g. Citizan of United		
020	urs after des frammes m by Fume	11. Meritel Stetus TO Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedant Ever in U Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas:		Wes Decede If Yas, specif		spanic Orig n, Maxican, Specify:	in? (Spe Puarto I	cify Yas or N Rican, etc.)	Bla	ce - Amaric ck, Whita, y: whi	atc.
21215-0020	wd within 72 ho ygiene. wr then "neturn ft, the Medical. Completed	15. Decedent's Edu (Specify only highest gred Elementary/Secondary (0-12)	cation a <i>complated)</i> Collega (1-4or 5+)		dent's Usual kind of work DO NOT use rity				ng	16b. Kind of B		dustry
Maryland 2	Mental Hyg arked other aftic event, I	17. Fethar's Nama (First, Middle, Last) Edgar R. Danie	elson							Angel		
altimore, Mar	mit. Pages 1 and 2 st partment of Health and portant: If flow 27 is in Injury or other traum	19a. Informant's Neme/Relationship (T) Lottie A. Danie 20a. Mathod of Disposition 1 Buriel 2 Cramation 3 F 4 Donation 5 Other (Specify) 21. Signature of Furnant Sarvice Licens	Lson - moth Ramoval from Stata Me	er 12 Place of Dispo cematary, cre tropo	869 B	ay a of nar place Cr	Dr. Novemat	Lus ory	by, M Data 2000		7 - City or To dria	wn, Stata Virginia
Be	Per Per Per Per Per Per Per Per Per Per	23a. Part1. Entar tha diseesa, or compl shock, or heart failura. List only o	licetions that caused the dea					s.	Rd. P			ic mD 206° Approximate Interval Batween
Box 68760,	bhysician and be detached for use as the burst that the death certificate be executed by the ettending physician and defeached for use as the burial-transit defeached for use as the burial-transit defeached for use as the burial-transit defeating the physician/Medical Examiner	Immediata Cause (Finel disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last	Due to (or as a conse on A or es a conse or as e consec	quence of):	hi	Mun	101H	system	n FaileR of Periku	'E	Onsat end Deeth
0	the deat y the att ached for hysicia	Part II. Other eignificant conditions con	ntributing to death but not res	sulting in the L	undarlying car	usa give	n in Part I.			tobacco uee co		the cause of death?
Division of Vital Records, P.	aw requests been 2 should							_	24a. Wa	s an autopsy formed?	24b. Wiev co	are autopsy findings aliable prior to mpletion of cause death?
on of Vita	hystelan his certifi al director To Be	25. Was case referred to medical axaminer? 1 Yes 2 No 27 Mannar of Death 1 Neturel 5 Panding 2 Accident invastigation	lospital: 1 Inpatiant 2 28a. Data of Injury (Month, Day Year)	ER/Outpatie		c. Injury Work	er: 4 🗆 Nur	rsing Ho		ona) sidanca 6 🗆 Oti how injury occu		y)
Divisi	tel or Attending P is after death. In Director: After t led in by the funera Certification:	3 Suicide 6 Could not be detarmined	28a. Placa of Injury - At h building, atc. (Speci	nome, farm, st	reet, fectory,	office			28f. Location City or To	(Streat and Num own, Stata)	ber or Rure	al Routa Number,
	Hospi 24 hour Funer stely fill	29a. Cartifier Certifying Physical Cartifier (Check only one)	ner: On the best of my knowner: On the basis of examination and mannar stated.	owledge, deet ation and/or in	h occurred at wastigation, i	t the tim in my op	e, date and inion, daat	d place, a	and dua to the	a causa(s) and m a, data end placa,	ennar as s , and dua to	tated. the cause(s)
	To the within To the comple	29b. Signature apti title of certifier	DOBER M	1	29c.	License	number 260	07		29d. Date signo	200	Day, Year)
		30. Nama and addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass of person who addrass o	V			מפת	EDIC	<i>y</i>	MD	20678		
	State Registrar	DR. SHELDON GO 31. Dete filed (Month, Day, Year) NOV 0 3		PRII	1	1	ERICI	κ,	MD :	20078		

DHMH 16 Rev 6/95



Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month WILLIAMS DODSON 2 November 2000 3:50 am 4a Facility Nama (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death 13th Street Chesapeake Beach Calvert If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Months 1□M 2XF Yrs. 65 May 3, Mississippi Usual Residence of Decedant 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 Yes 2 □ No Calvert Chesapeake Beach 10f. Zip Code 10g. Citizen of What Country? 13th Street

20732

Lydia

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

same as #10 a-f

22. Nama and Addrass of Facility

Metropolitan Crematory

20b. Placa of Disposition (Neme of cemetery, cremetory or other place)

METASTATIC LUNG CANCER

Due to (or es a consequenca of):

Due to (or es a consequence of):

Due to (or as a consequence of):

Williams

USA

White

Summerall

Approximate Interval Between Onset and Death

24b. Were eutopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

14. Race - American Indian Black, White, etc.

Specify:

Own Home

18. Mothar's Name (First, Middle, Meiden Surnama)

Date

11-03-00

Rausch Funeral Home, P.A., Owings, MD 20736

24a. Was an autopsy

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

1 Yes 2 No

28d. Describe how injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

2

29d. Date signed (Month, Day, Year)

2000

16b. Kind of Business/Industry

20c. Location - City or Town, State

Alexandria, VA

23b. Did tobacco use contribute to the cause of death? 12 Yes 2 No 3 Probably 4 Unknown

Director rai', or items 23a or 28a-f show Examiner must be notified at Director "natural", or items 23a Funeral p Completed

Physician

/Medical

Examiner

Funeral

JOLENE

1 Never Married 2 Married

15. Decedent's Education (Specify only highest grade completed)

3 Widowed 4 Divorced

Elemantary/Secondary (0-12)

Russell

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type, Print)

David R. Dodson / husband

1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removal from State

3911

5. Social Security Number

587-70-7324

10e. Street and Number

10a. Stete

MD

3911

11. Marital Status

72 hours after permit. Peges 1 and 2 should be filed within 72 hx Department of Health and Mental hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic avant, trailled in an

Be

2

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

The law requires that the death certificate be executed physician s the bune P.O. Box 68760, 93 bengis t be det Records. page 2 should certificate of Vital Hospital or Attanding Physician: 24 hours after death. Funeral Diractor: After this certifica director. the funeral Division filled in by

Examiner Physician/Medical þ Completed Be edical Certification: To

4 ☐ Donation 5 ☐ Other (Specify) .234. Part1. Enter the disease, or complication, the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cad a fine each line. 27. Manper of Death 1 Naturat
2 Accident

fmmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enler Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part fl. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was casa referred to medical exeminer? 1 Yes 2 No

3 Suicida

29a, Certifier

4 Homicide

29b. Signatura and titla of certifier

12

State

Registrar

within 24 hours a To the Funeral C completely filled

To the

Peter Wisniewski, M.D., 31. Date filed (Month, Day, Year) NOV 0 6 2000

5 Pending Investigation

6 Could not be determined

28a. Date of Injury (Month, Dey Year)

12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Datas:

College (1-4or 5+)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrarie Signature

28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

Injury

40370 Dunkirk, MD

28c. Injury at Work?

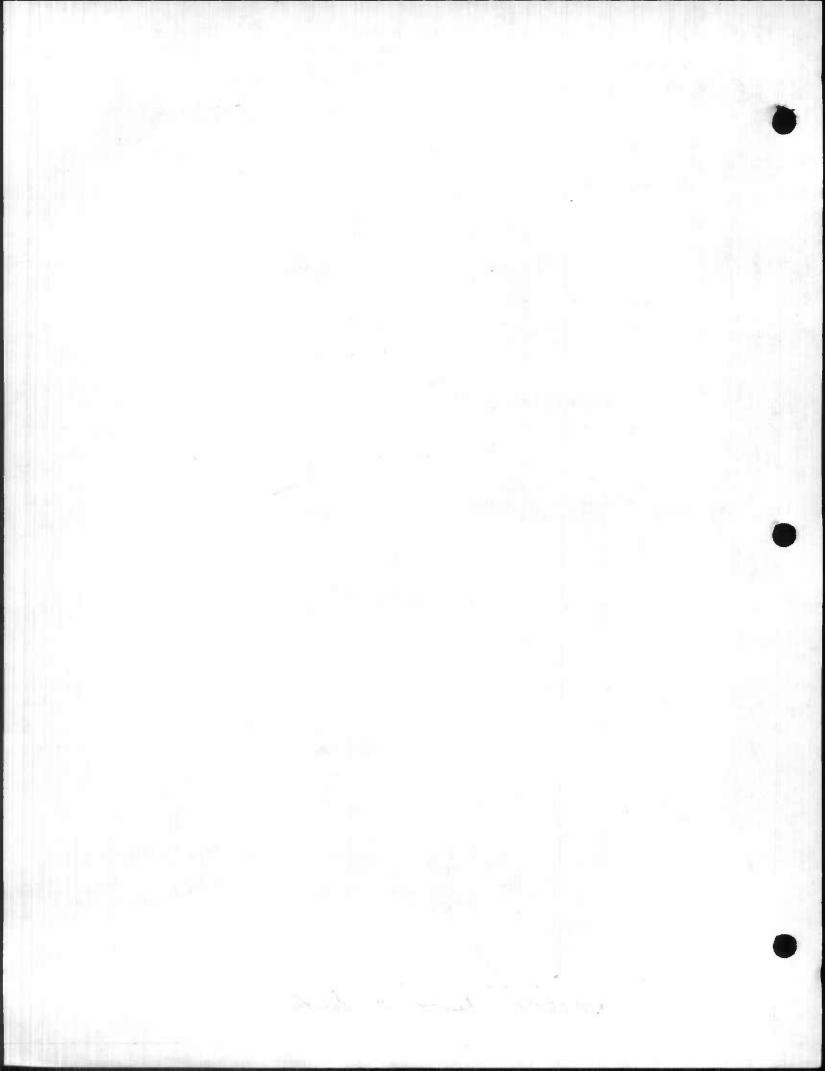
Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and pleca, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and plece, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

hener

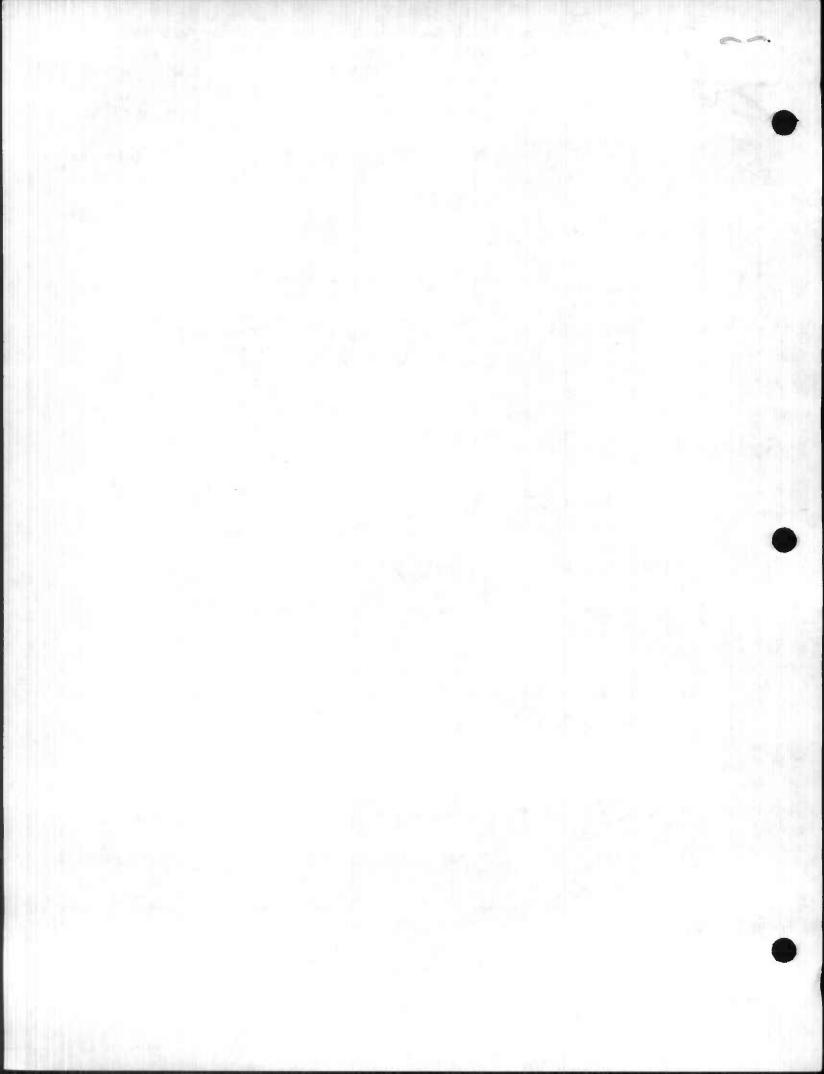


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State of Maryland / Department of Health and Mental Hygiene 10 36193

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		ame/Relationship (***				et and Number or Ru					
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DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** DARDEN OCTOBER 23, 2000 VERNICE 6:00 AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner PRINCE GEORGES 2512 BUCKLODGE TERRACE ADELPHI 8. Dete of Birth JAN. 23, 1936 NORTH CAROLINA If Under 1 Year If Under 24 Hrs. 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Deys Hours Min 1 M 2 F 64 Yrs. 239-52-8558 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 No MARYLAND PRINCE GEORGES **ADELPHI** Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? mart he n 20783 UNITED STATES 2512 BUCKLODGE TERRACE Funeral 14. Race - American Indian, Black, White, etc. 12. Wes Decedenf Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Meritel Status Yes 2 No f Yes, Give Yeer or Dates: 1 □ Never Merried 2 □ Married Specify: AFRO-AMERICAN 1 Yes 2 No Specify: by 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiena. other than PRIVATE Elementery/Secondery (0-12) College (1-4or 5+) 12TH COSMOTOLOGIST/BARBER 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be 2 should be and Mental ARNOLD STANCIL VIOLA REDMOND STANCIL Pages 1 and 2 should be ment of Health and Menta ant: If hem 27 is marked 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) GRAND-DAUGHTER STACEY M. DARDEN 2512 BUCKLODGE TERRACE, ADELPHI, MD 20783 20b. Place of Disposition (Name of cametery, crematory or other place)
GEORGE WASHINGTON CEMETERY 10-28-2000 ADELPHI, MD 20e. Method of Disposition 1 □ Quriel 2 □ Cremetion 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility DUDLEY FUNERAL HOME 20712 MT. RAINIER, MD 3200 RHODE ISLAND AVE. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest 0 Due to (or es a consequença of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown by 24e. Was en autopsy parformed? 24b. Were autopsy findings aveilable prior to Completed completion of cause of death? page 2 No 1 Yes 2 No 1 Yes Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No this 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred of or Attending Pattern of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Country of the Count 1 Aletural 2 Accident 5 Pending investigation 1 Yes 2 No 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 6 Could not be illed in by 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) and manner as steted.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end plece, end due to the cause(s) and menner steted. 29a. Certifier (Check only one) 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signafure and fittle of certifier D38262 30. Neme and address of parson who completed cause of deeth (Item 23a) (Type, Print)

State Registrar

Merchi 31. Date filed (Month, Day, Year) OCT 3 0 2000

2401 32 Registrar's Signeture

Research

BLYD

Rockville MD 2085

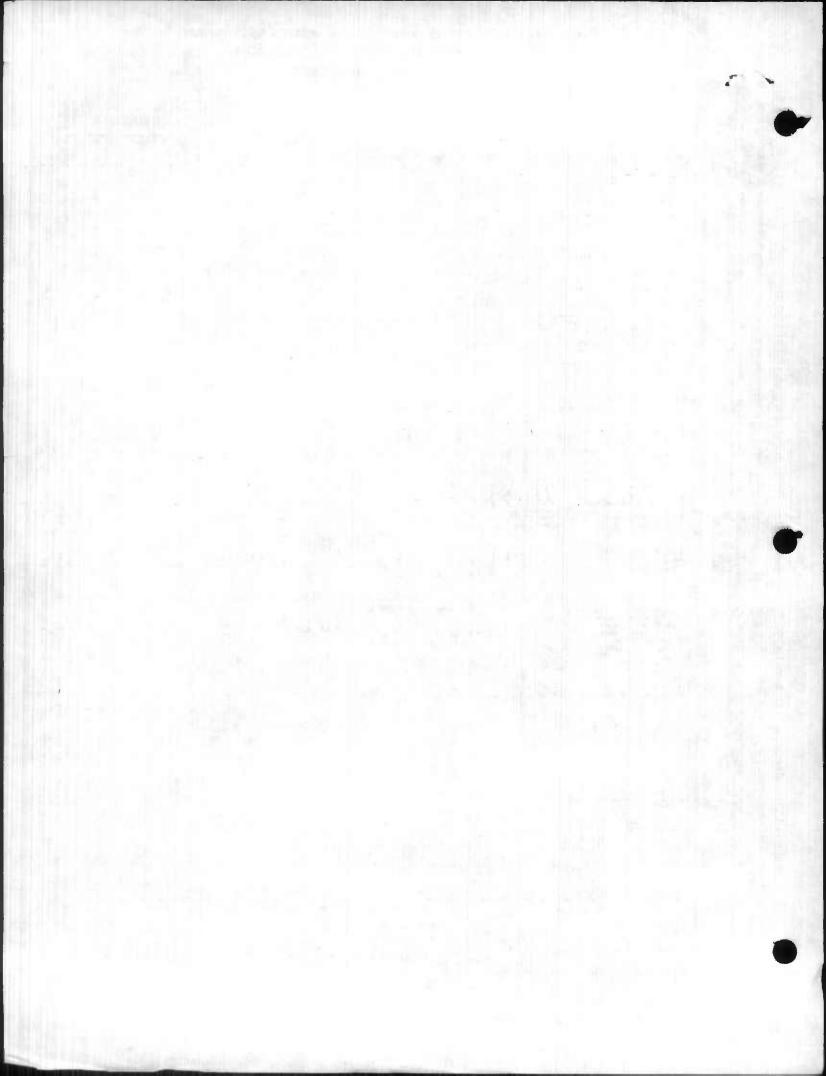
Baltimore, Maryland 21215-0020

Box 68760.

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Division

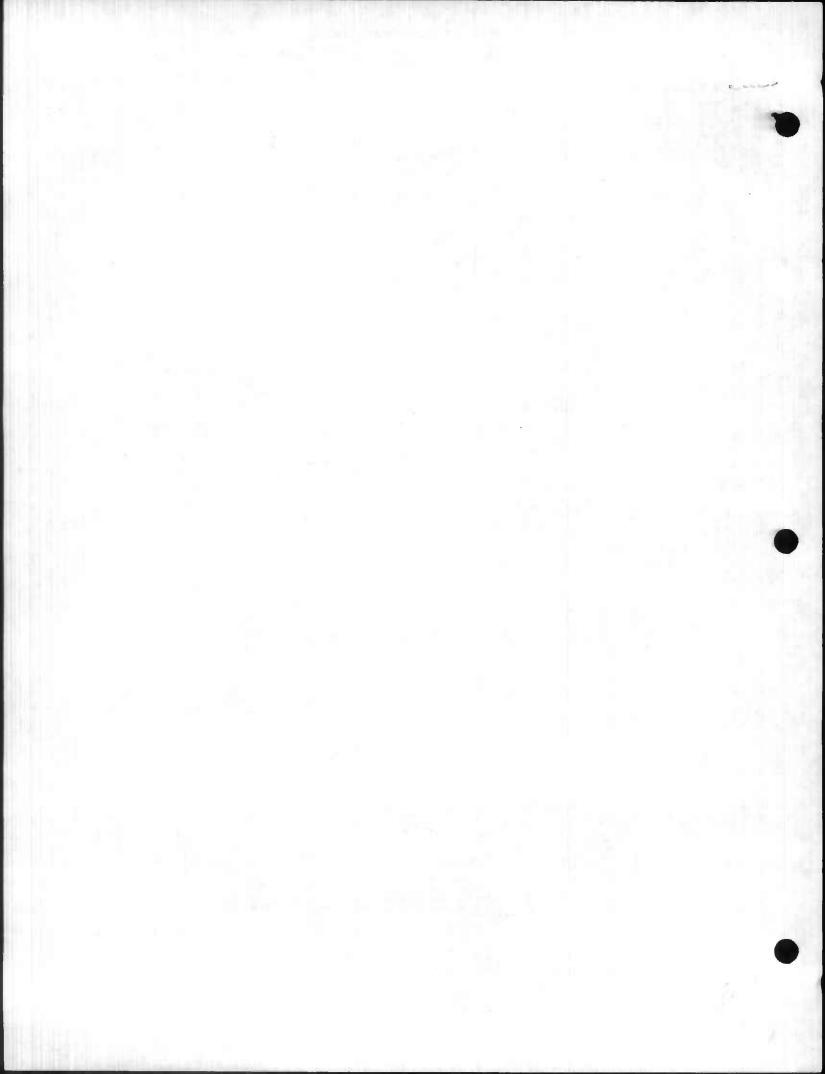


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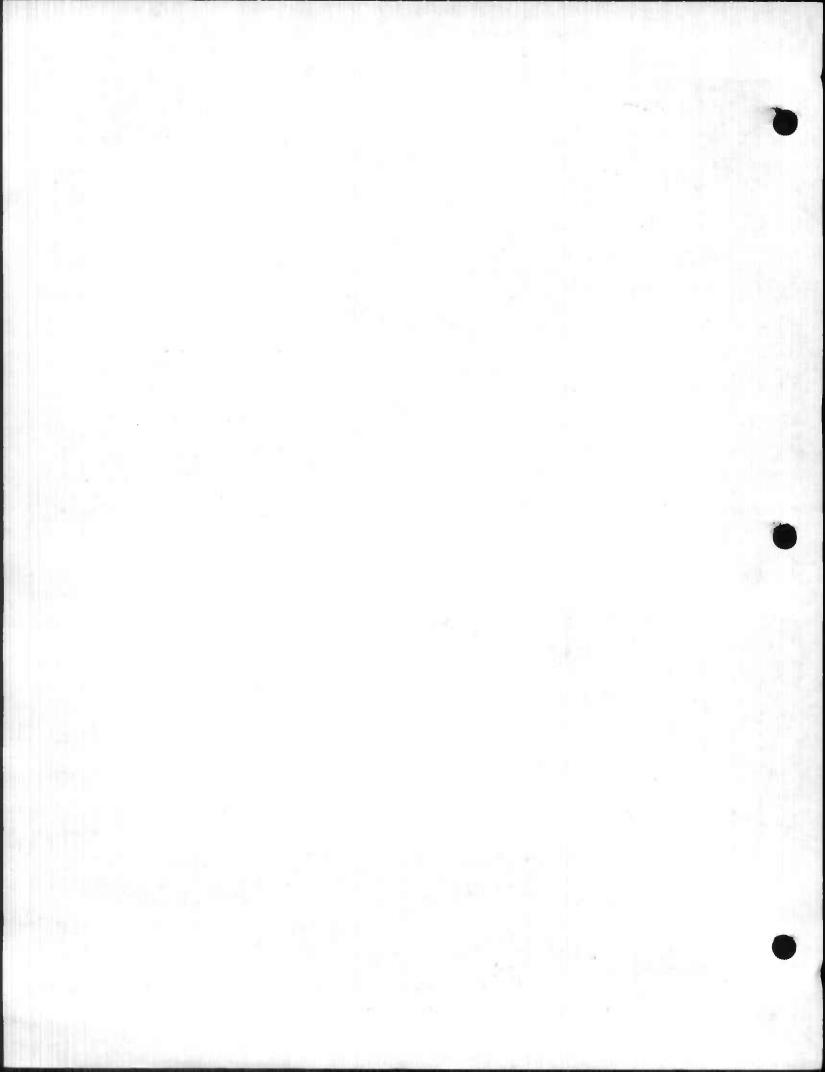
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	Funeral	5. Social Security Number 6.	Sex 7. Age (In yr.	s. lest birthday)	If Under 1 Y Months D	aar If Und	der 24 Hrs.	8. Dete of Birt (Month, Da)	h v, Year)	9. Birthp	olace (State or Foreign
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	within 24 hours after death To the Funeral Director: / completely filled in by the i Medical Certificat	one)	end manner steted.								
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	(5)	30. Name and address of person who						11 11	34.1	207	16
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	/Medic		4a Facility Name (If not institution	on, give :	street and ne	um <i>ber</i>)				4b. City, To	wn, or Lo	ocation of Deal		unty of D		
7	Examin	er	12704 Lunan R							Cli	nton		Dr	ince	Georg	res
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Ĕ	Page		4 Donation 5 Other (emoval from								Chel	tonk	am N	Maryland
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л	300		23a. Parti. Enter the disease, of shock, or heart failure. Lis	r compli	ications that	caused the dea	ath. Do not ent	ter the mod	de of dy	ring, such as	cardiac	or respiratory	arrest,		Appr	roximate rval Between
	Physician														Onse	et and Death
	/Medical		Immediate Cause (Final		51	idde	20 0	200	VI	00	01	on the	1			7
	Examiner		disease or condition resulting in death)						w	nc	U	Coll	1			0
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00			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events)	h	JOUR	HMS	SIDK	7						Dr	reyelle
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Division	or Attending after death. Director: Afte I in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could		28e Plec	a of Injury - At	home farm str	reet factor	v. office	9		28f. Location	(Street and I	Vum <i>ber</i> c	or Rural Rou	uta Number,
2	or Direction	팊	4 Homicide	mined	build	ding, etc. (Spec	ify)		,,			City or To	own, State)			
_	illed in															
	Hospital 24 hours Funeral stely filled	edical	(Check only 2 Medical			e best of my kn basis of examin										
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	8	one)			nner stated.										
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	(15)	-	30 Name and address of party	uho a	mpleted ac	ICO OF THE PER	m 93a) (Tues	Print)	10	-51	- /					
	1101		30. Name and eddress of persor		10	2 2 1	ad 4	2 2	2.	1		P	2.	1	·Ca	2000 wg, md.
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	Stat	е	31. Date filed (Month, Day, Year	กกก	37	Registrar's Sign	eruren	Asa	1h	1					, ,	1

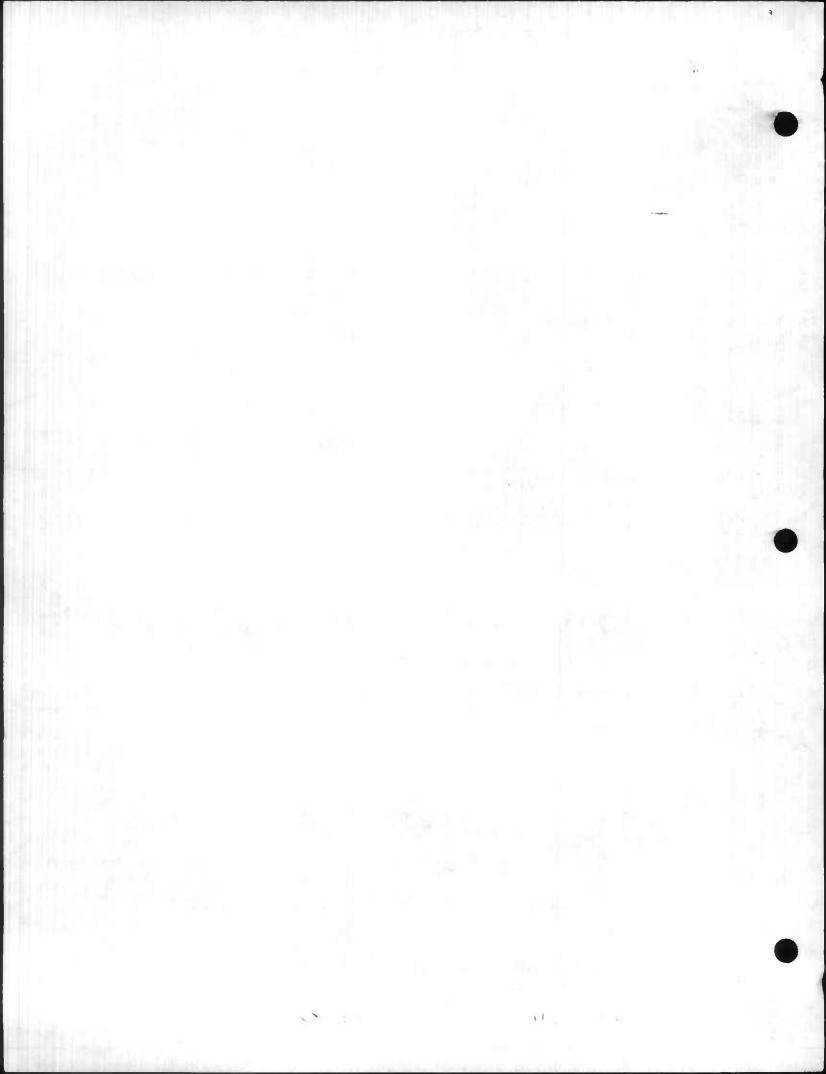


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State of Maryland / Department of Health and Mental Hygiene Amended item 10e perFHG789 11/30/2000 EW Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Death 3. Tima of Death Month **Physician** 4, Nell M. Decker 2000 Nov. 8:45 am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FutureCare Chesapeake Arnold Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) NOV. 10, 1924 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthpleca (State or Foreign Country) **Funeral** Months 1 M 25 F Days Hours 75 233-38-4502 Director West Virginia Usual Residence of Decedent the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Culpepper Culpepper 1 Yes 20 No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Peges 1 and 2 should be filed within 72 hours after deeth with and Mentel Hygiene.
Intelf Hem 27 Is marked other than "natural", or hema 23a or any or other traumatic evant, its Media. 15016 Chestnut Fork Road 22701 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 25 Married White 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Nema (First, Middle, Maiden Sumema) Albert Garrett Christian Cassie Williams 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Porter S. Decker, Jr./Husband 15016 Chestnut Fork Road, Culpepper, VA 22701 20a. Method of Disposition 20b. Ptece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata permit. Peges
Department of
Important: If it
eny injury or o 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Nov 8, Rosewood Cemetery Lewisburg, WV 2000 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete tnterval Between Onset end Death Physician Schemuc /Medical Immediate Cause (Finet disease or condition resulting in death) weeks Examiner Due to (or as a consequence of) weely Examine Coestro untes final bleed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Obstratue Pulmonary descesse physician the burial wonic Box 68760. Physician/Medical Due to (or as a consequence of): Peripheral Vascular disease (week 25 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. Yes 2 No 3 Probably 4 Unknown Records. ð 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 Yes 2 X No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 No 8 26. Placa of Deeth (Check only one) Other: Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Aftar this 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of tnjury (Month, Day Year) 28c. Injury et Work? 5 Pending investigation 1 (Watural death. 1 Yes 2 No Nepital or Attending Purpose after death Puneral Director: / plately filled in by the 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

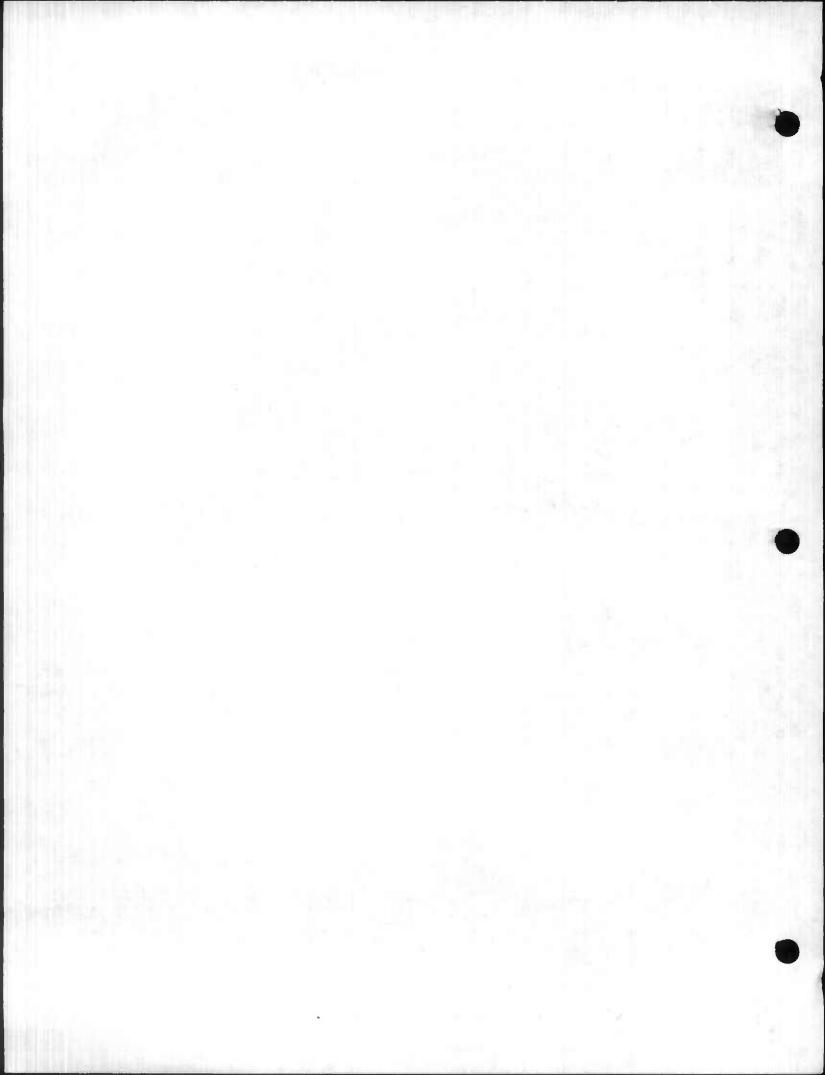
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completely fi (Check only one) \$ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11-4-00 D40519 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7845 OAKawad Road, alen Burne 2166, MIREA M. NUSAIREE 31. Data filed (Month, Day, Year) 32. Registrar's Signeture State NOV 0 8 2000 Registrar



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State of Maryland / Department of Health and Mental Hygiene 00 36498

						Ce	rtificat	e of i	Death			Reg. No.		
п	Di dida	1. Decedent's Nan	na (First, Middle, La	st)							2. Data of De Month	eath Day	Year	3. Time of Death
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	Examiner	4a Facility Name	(If not Institution, giv	e street end nun	mber)			4	4b. City, To	own, or Lo	cation of Deat	h 4c. C	County of Death	
		Anne Art	undel Med	ical Cer	nter				Anna	apoli	.s	Anı	ne Arun	del
	Funeral	5. Social Security		The second second	7. Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Undar Hours	24 Hrs. Min.	8. Date of Bir (Month, De Mar. 2	th Vest	9. Birth	place (Stete or Foreign ntry)
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20	0 0 0		riad 2 Married 4 Divorced	1 ☐ Yes If Yes, Giv	a	*	1 🗆 Yes	2 XNo	Specify:			S	Specify: Wh	ite
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12	within then then then then then then then the	Elamentary/Sec	ondary (0-12)	College (1	-4or 5+)		Homem						Home	
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Maryland	and Men and Men sumatic		lame/Raiationship (Type, Print)	5 71 %	19b. Maili	ng Addrass	(Street	end Numb	er or Rur	al Route Numb	er, City or	Town, State, Zi	p Code)
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re,	ges 1 and 2 should be filed within to f Health and Mental Hygiene. If Itam 27 is marked other than or other traumatic avant, If a Me To Be Comp	20a. Method of Dis	sposition	VI. 1.19	20b. F	Place of Dispo	sition (Ne	na of			Date		ation - City or T	own, State
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	-	23a. Part 1. Entar	the disaase, or com	plications that co	aused the deat								rain, M	Approximate
of.	Physician	shock, or he	art failura. List only	one cause on e	ach line.	^	0		,					tnterval Batween Onset and Death
	/Medical	tmmediate Cause	(Final	R	pture		6.0	1	a / a	end	C (1)	LAUV	1511	
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o,	an an inial-t	Sequantially list of fany, laading to it cause. Entar Und Cause (Disease of that initiated event	mmediate lertying											
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× 68	ertificate be executing physician and se as the bunial-tran													
Bo	tend or us			0										
_0	the atter thed for a	Part II. Other signi	ificant conditions	contributing to de	ath but not ras	ulting in the u	nderlying o	ause giv	en in Part	i.	23b. Did	tobacco u	as contribute	to the cause of death?
P.0	The lew requires that the death cer- cate has been signed by the attendin page 2 should be detached for use Completed by Physician/N	Conor	avy ca	tern	Dise	- 60	at	119	1		10	Y88 2	No 3□Pr	obably 4 Unknown
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of Vital	yalclan: The lev is certificate has director, page 2 To Be Comp	25. Was case refe examiner?	rred to medical				311		26. Plac	e of Deat	h (Check only	one)		
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Ω	iled i				W. Free									
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	29a. Certifier (Check only	Certifying Pt	niner: On the ba	isis of examina	wledge, deat tion and/or in	h occurred vestigation	at the tin	na, date ar pinion, das	nd placa, ath occur	and dua to tha red at the tima,	cause(s) a data and p	and manner as placa, and dua	stated. to the cause(s)
	within 2 To the comple	one) 29b. Signature and		and mann	ner states)			a number				signed (Month	
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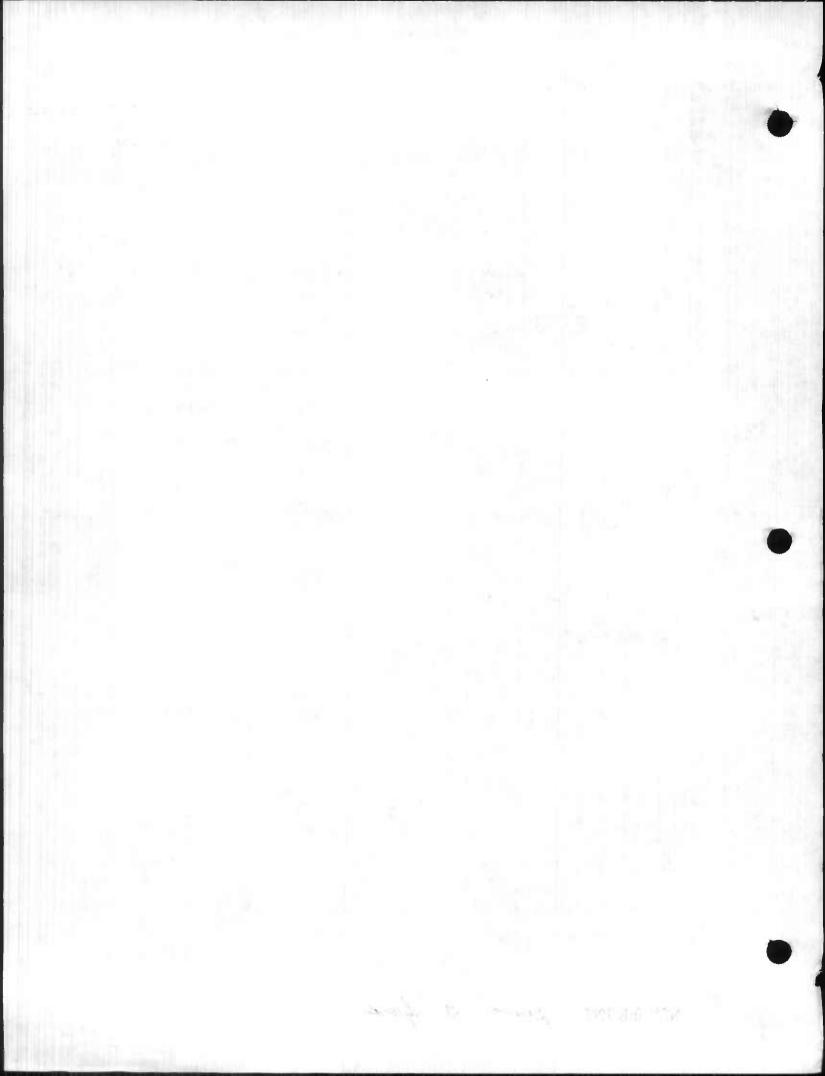


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State of Maryland / Department of Health and Mental Hygiene	J	D I	1	1.	1
Certificate of Death					

			Ce	rtificate	of Death	7	Reg. No.				
	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year										
Physician /Medical	DOROTHY MARY		Novem	_		23:00 P.M					
Examiner	4a Facility Name (If not institution,	give street and number)			4b. City, T	own, or Location of D					
	SACRED HEART	RLAND	ALLE	GANY							
Funeral Director	218 12 5892	1□M 2X F	M 2XF 7. Age (In yrs. last birthday) If Under 1 Y Months D			Min. (Month,					
Libe notified at	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				1	Od. Inside City Limits		
or 28s-f show be notflind at Director	MARYLAND ALLEGA										
Dir	16012 FOUNDD		10g. Citizen of	Whet Cour	niry?						
E 23 E	16012 FOUNDR					rigin? (Specify Yes or	U.S. No- 14. Rece - American Indian,				
by by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?	1 ☐ Yes 2 No If Yes, Give 1 ☐ Yes 2			rigin? (Specify Yes or an, Puerto Rican, etc.) v:		Black, White, etc. Specify: WHITE			
ygiene. ner than "naturn nt, fre Medical.	15. Decedent's (Specify only highest	Education	16a. Dece	dent's Usuaf C	occupation fone during mo	est of working	16b. Kind of B	-			
than 'n	Elementary/Secondary (0-12)		College (1-4or 5+)			al or working					
other th	8		HOM	IEMAKER	1 44 44 4		OWN				
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- E	19a. Informent's Name/Relationship RICHARD DUNN / S			-		ber or Rural Route Nu 'ROSTBURG,		, State, Zip	Code)		
rages I and ent of Heelth mt: If Item 27 ry or other t	20a. Method of Disposition 1 X Burial 2 Cremetion 3 4 Donation 5 Other (Spe		20b. Place of Disponentery, creed ST. PATRI	metory or othe	r place)	Date 11/6/00					
Departmen Important: any injury once.	21. Signature of Funeful Service Lic	ensee	S	OWERS		HOME, P.A	١.				
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0 8 0	that initiated events resulting in death) Last	Due to (or as a consequence of):									
gned by the attendii be detached for use by Physician/I	Part II. Other significant conditions	contributing to deeth but	not resulting in the u	inderfying cau	se given in Per	ı f. 23b. [Old tobacco use co	ontribute t	o the cause of death?		
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should should	DIABRITES	MANERY	BUSEASE				Ves an eutopsy erformed?	av cc	ere autopsy findings allable prior to impletion of cause		
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this certificate rel director, pag TO Be Co	25. Was case referred to medical				26 Dia		,	1	☐ Yas 2☐ No		
his certifical director	examiner?	Hospital:	t 2 ER/Outpatie	nt 3 DOA	Other:	ce of Death (Check or		her /Sneci	fv)		
on The	27. Manner of Death 1 Netural 5 Pending 2 Accident investigat	28a. Date of Injury (Month, Dey	28a. Date of Injury 28b. Time of Injury at Work?					y Home 5 ☐ Residence 8 ☐ Other (Specify) 28d. Describe how injury occurred			
rs after death. al Director: After to led in by the funere Certification:	3 Suicide 6 Could no 4 Homicide determine					28f. Location City or	28f. Location (Street and Number or Rurel Route Number, City or Town, State)				
within 24 hours after death. To the Funeral Director: A completely filled in by the fu	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	he time, date a my opinion, de	and place, and due to the cause(s) end menner as stated. seth occurred et the time, dete end place, and due to the cause(s)								
within To the compl	29b. Signeture end title of certifier	c	end manner stated. 29c. Lic				29d. Date signed (Month, Day, Year)				
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State of Maryland / Department of Health and Mental Hygiene 36500

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Physic	ian								2.	Month NOV.	81, 2	OYAN	1:02PM	
/Medi	cal	4a Facility Nama	Truman D		mharl			4b. City, Tow	m or Locati				1.02111	
Examiner	ner		a Medica						aPlata		of Death 4c. County of Death Charles			
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. In 2015) 83					If Under 1 Yaer Months Days	Min.	Data of Birt (Month, Day 2-01-1	ate of Birth fonth, Day, Year) -01-1917 9. Birthplace (State or Foreign Country) Maryland				
21215-0020 4 within 72 hours after death with the Maryland plens. I then "natural", or herns 23e or 28e4 show the Medical Examiner must be notified at completed by Funeral Director.		Usuel Rasidence of	10b. County		10c. Ci	ty, Town or Lo	cation					1	0d. Insida City Limits	
	to	Maryland	Charle	G	Nanjemoy					10)				
	10a. Street end Number 10f. Zip Code									10g. Citizen of	What Coun	itry?		
	8545 Gi	lroy Roa	d	20662					Ţ	Inited States				
	nec	11. Marital Status	12. Was Dece	12. Was Decedent Evar in U,S. Armed Forcas? 13. Was De			ecedent of Hispanic Origin? (Specify Yes of specify Cuban, Maxicen, Puerto Rican, ato				ce - Americ	an Indian,		
	by	1000	ried 2 Merried	1 ☐ Yas If Yas, Giv	1 Yas 2 No If Yas, Giva Yeer or Detes:		1 ☐ Yas 2 ☐ No Specify:					Specify: Black		
72 h	Completed	(Spe	15. Decedent's	Education grada complated)	ation 16		16a. Decedent's Usual Occupation (Giva kind of work done during most of w		of working		16b. Kind of B	usiness/Ind	dustry	
Z de se	mpl	Elementary/Sec				life.	DO NOT use retire	itired)			Construction		n Company	
D The d		17 Father's Name	8 Laborer Father's Name (First, Middle, Last) 18. Mother's Nam						's Nama (F)	Construction Company ma (First, Middle, Malden Sumame)				
and do	To Be	Lemuel							Gain			,		
A PARTY	F	19a. Informant's N		(Type, Print)		19b. Meilie	ng Address (Stree				er, City or Town,	Stata, Zip	Code)	
Manda altha 27 is		James E.	Thomas/	Nephew									yland20607	
More, Pages 1 a sent of Hea rit: If Nam riy or othe		20a. Mathod of Dis	sposition		20b.		sition (Nama of metory or other pla			Data -06	20c. Location		-	
Page Page ny or			□ Crametion 3 5 □ Other (Spe		State		e Baptis				Nan jemoy	,Mar	yland	
Ball.		21. Signeture of F	unaral Sarvice Lic	ensaa 2 ///			Name and Addr				Α.		42'	
20260		h	leph	ella		0668 4	270 Hawt	horne	Road,	Indian	n Head,	Maryl	and 20640	
	В	23a. Part1. Enter shock, or ha	the disease or co erthallum. List on	mplications that of ly ona causa on a	eused the daa ach line	th. Do not ant	ar the mode of dy	ing, such as o	ardiac or re	aspiratory ar	rast,	1	Approximate Interval Batween Onset and Death	
Physician /Medical		Onset											Oriset and Death	
Examiner		Immediate Cause (Final disease or condition rasulting in death) a												
1 2 X X	5				Dua to (or as a consec	(uence of):	-1.0						
b bring	Examiner	Sequentially list o	onditions (b	Due to (or as a sanses	ouence of ()	wen	-	-		- 1		
U, an and arrand														
DESTOU, ficals be a physician is the buria	edical	Cause (Disease or Injury that initiated evants rasulting in death) Last Due to (or es a consequenca of):												
D 5 0 8														
0 1 10	Physician/M	Part II Other elani	ificant conditions	contributing to de	eath but not re-	culting in the u	ndedvina ceuse a	van in Part I		23h Did i	tohacco use co	entribute to	o the cause of death	
P.O.	hys	Part II. Other significant conditions contributing to death but not resulting in the underlying						730 girdir #17 dif (.			1 Yee 2 Probably 4 Unknow			
S, T	ру Р													
en signe	Pe										an autopsy	ev	ara autopsy findings aileble prior to	
ABC Sh	Completed											of	mpletion of cause death?	
VITAL MAC,	EO									101	res 2 No	10	∃Yes 2□No	
Han: Inntificu	Be	25. Wes case refe axaminar?	rred to medicel					26. Place	of Deeth (C	heck only o	ona)			
Digital of the second	70	1 Yas 2		Hospitel: 1 🔲	Inpatient 2	ER/Outpatier	II JU DUA		sing Homa	5 🗆 Rasio	dence 6 Ott	nar (Specil	y)	
sion o	on:	27. Menner of Dea	5 Panding	28a. Dete of Injury (Month, Day Year)				rry at 28d. Dascril		I. Dascribe I	ribe how injury occurred			
	cat	2 Accident invastigation M 1 Yas 2 No 3 Suicide 6 Could not be 38 Place of John At home from street factory office.								Location //	/Street and Number or Burel Bouts Number			
Direct At In Dy	entit	3 Suicida detamined detamined 28a. Place of Injury - At home, farm, streat, factory, office building, atc. (Specify)							201.	 Location (Street and Number or Rurel Route Number, City or Town, Stete) 				
he Rospital n 24 hours he Funeral pletsly filled edical Ce														
To the vithin 2 To the comple	Med	one)	title #f certifier	and man	nar steted.		29c Licen	sa number			29d Data signs	ed (Month	Day Year)	
5 4 5 0 S		29b. Signatura and title of certifier D-21031							29d. Data signed (Month, Day, Year)					
		30. Nama and add	rass of person who			m 23a) (Type, 12070	Print) O Old Lii	ne Cent	ter #2	202 Wa	ldorf.	MD 20	0602	
St	ate	31. Date filed (Mod	nth, Day, Year)	32. R	legistrar's Sign		1							
Regist	rar		NOV 03	2000	Depense	Ø.	14000	2/						

